

Thank you for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information				Today's Date			
Name			Birthday			Social Security Number	
Address		City			State	Zip Code	
Home Phone	Phone Business Phor			Cell Phone	one		
Email Address - Would you like to receive appointment remind	ers by email?			Drivers Lic	ense Number	ense Number	
Marital Status Single Married Divorced Widow	ed Other	Patient Em	Patient Employer			Occupation	
Employer Address		City			State	Zip Code	
Spouse / Partner Name		Spouse / Pa	artner Phone		Relationship t	Relationship to Patient	
Whom / what may we thank for referring you?							
Emergency Contact (Someone who does not live with you)		Emergency	/ Contact Phone Number		Relationship t	o Patient	
Responsible Party							
Name of Person Financially Responsible for this Account							
Relationship to Patient			Is this Person a Patient in Our C	Office?			
Address (if different from above)		City		State		Zip Code	
Social Security Number	ity Number Birthday			Drivers License Number			
Home Phone	ome Phone Business Pho		ne Cell Phor		one		
Primary Dental Insurance Information							
Name of Insured			Relationship			ip to Patient	
Social Security Number	Birthday			Drivers License Number			
Name of Employer Date Employed							
Employer Address	Employer Address		City		State	Zip Code	
Insurance Company	Group Number		Employer Nu		lumber		
Insurance Company Address		City			State	Zip Code	
Additional Dental Insurance Information							
Name of Insured Relationship to Patient							
Social Security Number	Birthday			Drivers License Number			
Name of Employer Date Employed							
Employer Address City			State		Zip Code		
Insurance Company	Group Number Employer Number						
Insurance Company Address			City			Zip Code	



960 N. Hamilton Road, Suite 107 I Gahanna, Ohio 43230 **Phone:** 614-467-8999 **Fax:** 614-478-0619

www.mvanhuffel.com **Medical History** Patient Name Birthday Although dental personnel primarily treat the area in and around your mouth, your mouth is party of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. • Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain? • Have you ever been hospitalized or had a major operation? $\ \square$ Yes $\ \square$ No If ves, please explain? Have you ever had a serious head or neck injury? ☐ Yes If yes, please explain? Are you taking any medications, pills or drugs? ☐ Yes If yes, please explain? • Do you take, or have you ever taken, Phen-Fen or Redux? ☐ Yes If yes, please explain? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosponates?
 □ Yes
 □ No If yes, please explain? Are you on a special diet? ☐ Yes ☐ No • Do you use tobacco? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No • Are you pregnant/trying to get pregnant? ☐ Yes ☐ No • Taking oral contraceptives ☐ Yes ☐ No • Nursing ☐ Yes ☐ No · Are you allergic to any of the following? □ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal □ Latex □ Sulfa drugs □ Other If yes, please explain? • Do you have, or have you had, any of the following? AIDS/HIV Positive ☐ Yes ☐ No Cortisone Medicine Hemophilia **Radiation Treatments** ☐ Yes □ No ☐ Yes □ No ПΝο ☐ Yes ☐ Yes ☐ No Diabetes Hepatitis A **Recent Weight Loss** Alzheimer's Disease ☐ Yes □ No ☐ Yes □ No □ Yes □ No Anephyiaxis **Drug Addiction** Hepatitis B or C Renal Dialysis ☐ Yes □ No ☐ Yes □ No □ Yes □ No ☐ Yes □ No Rheumatic Fever **Easily Winded** Anemia ☐ Yes □ No ☐ Yes □ No Herpes ☐ Yes □ No ☐ Yes □ No High Blood Pressure ☐ Yes Rheumatism Emphysema Angina □ Yes □ No ПΝο ☐ Yes ☐ No ☐ Yes ПΝο Arthritis/Gout □ Yes ПΝο **Epilepsy or Seizures** □ Yes □ No **High Cholesterol** □ Yes □ No Scarlet Fever ПΝο □ Yes Artificial Heart Valve ☐ Yes □ No **Excessive Bleeding** ☐ Yes □ No Hives or Rash ☐ Yes □ No Shingles ☐ Yes □ No **Artificial Joint** ☐ Yes □ No **Excessive Thirst** ☐ Yes □ No Hypoglycemia ☐ Yes □ No Sickle Cell Disease ☐ Yes ПΝο Irregular Heartbeat ☐ Yes Sinus Trouble Asthma ☐ Yes □ No Faining Spells/Dizziness ☐ Yes □ No □ No ☐ Yes □ No **Kidney Problems Blood Disease** ☐ Yes Frequent Cough ☐ Yes □ No ☐ Yes □ No Spina Bifida ☐ Yes □ No □ No **Blood Transfusion** □ No Frequent Diarrhea □ No Leukemia □ No Stomach/Intestinal Disease ☐ Yes □ Yes □ Yes □ Yes ПΝο **Breathing Problem** ☐ Yes □ No Frequent Headaches ☐ Yes □ No Liver Disease ☐ Yes □ No Stroke ☐ Yes □ No **Swelling of Limbs Bruise Easily** ☐ Yes □ No **Genital Herpes** ☐ Yes □ No Low Blood Pressure ☐ Yes □ No ☐ Yes □ No Lung Disease Thyroid Disease Cancer Glaucoma ☐ Yes ПΝο □ Yes ПΝο □ Yes ПΝο ☐ Yes ПΝο Mitral Valve Prolapse ☐ Yes Chemotherapy Hay Fever ☐ Yes □ No □ No **Tonsillitis** ☐ Yes ☐ Yes □ No □ No Heart Attack/Failure **Tuberculosis Chest Pains** ☐ Yes □ No ☐ Yes □ No Osteoporosis ☐ Yes □ No ☐ Yes □ No Cold Sores/Fever Blisters **Heart Murmur** Pain in Jaw Joints **Tumors or Growths** ☐ Yes □ No □ Yes □ No □ Yes П № ☐ Yes ПΝο Congenital Heart Disorder ☐ Yes □ No Heart Pacemaker ☐ Yes \square No Parathyroid Disease ☐ Yes □ No Ulcers ☐ Yes □ No Venereal Disease Convulsions Heart Trouble/Disease Psychiatric Care □ No ☐ Yes □ No ☐ Yes □ No ☐ Yes □ No ☐ Yes Yellow Jaundice ПΝο ☐ Yes

Patient Dental History

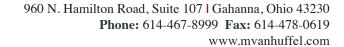
• Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain?

Name of Previous Dentist					Last Exam Date		
Do you clench/grind your teeth?	☐ Yes	□ No	Do you like your smile/color of teeth? ☐ Yes Have you had orthodontic treatment? ☐ Yes Do you have pain or sensitive teeth? ☐ Yes	□ No	Do you wear dentures/partials?	☐ Yes ☐ Yes ☐ Yes	□ N -

Authorization and Release

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or heath care practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Signature	Date





Health Insurance Portability and Accountability Act

Please answer all the questions may marking the appropriate box/filling in blanks. Thank you.

Patient Name		
· May we audibly say your na	ıme in our patient lobby, in or	der to identify you? 🗆 Yes 🗆 No
• May we use all of your cont	act numbers and addresses to	o stay in touch with you? 🗆 Yes 🗆 No
May we leave messages in y	your absence? □ Yes □ No)
• With whom may we discuss	your dental care?	
Name		Relationship to Patient
 Who can pick up your writt 	en prescriptions?	
Name		Relationship to Patient
• We routinely give reminder	calls prior to appointments. V	Vhere can we reach you?
Home Phone	Business Phone	Cell Phone
• May we call you at work?	 □ Yes □ No	
the terms of the privacy notice by phone or in writing. I unde been disclosed. I also have the	e may change and I may obtain rstand I have the right to reque e right to restrict how this infor	part of this registration process. I understand that in these revised notices by contacting the practice est how my protected health information (PHI) has mation is disclosed, but the practice is not strictions on PHI use, it is bound by that
Signature of Patient/gua	rdian	
Date of Birth		Date
Patient Unable To Sign D	ue To:	
Patient Refused To Sign		
Witness		Date



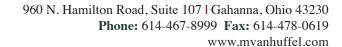
Appointment Guidelines & Agreement

Since providing quality treatment for all of our patients in a timely manner is a major focus on our practice philosophy, we would like to clarify our appointment guidelines with you and ask that you assist us in this endeavor.

There will be absolutely no charge for your need to reschedule an appointment provided you give us 48 hours notice and that you contact us during business hours, this would allow us the opportunity to give this time to another patient who is in need and waiting.

Last minute cancellations can cause hardships for many individuals. It is our sincere hope that you will accept these guidelines and join us in our efforts to provide quality time for you and each valued patient in our practice.

Thank you.		
Signature of Patient/guardian	Date	
Maria Van Huffel, D.D.S (Initial)		





Thank you for choosing our office for your dental needs. We do our absolute best to help you estimate your insurance benefits. As a courtesy, our office will verify your insurance with your insurance carrier as long as you provide us with your correct insurance information no less than 2 business days before your appointment. We will file your dental claim with your insurance carrier. Keep in mind all insurance companies include a disclaimer stating verification does not guarantee payment.

Due to the thousands of insurance plans, it would be impossible for us to know all benefits, allowances and limitations on all plans. You must be familiar with your own benefits. Your dental insurance plan is a contract between you, your employer, and the insurance company. *It is your responsibility to know the benefits, limitations and exclusions of your dental* plan. If you are unhappy with your coverage, please contact your Human Resources Department. Only your employer can change the policy. *We are not responsible, nor can we guarantee, how your insurance carrier will pay on a claim.*

When Dr Van Huffel recommends treatment, you will always be presented with a treatment plan for the services. Treatment plans sometimes change during the course of treatment because conditions worsen and therefore your financial responsibility would also change. This would always be discussed with you before service is rendered. The entire fee for services is your responsibility regardless of insurance involvement. Because your insurance company makes no guarantee of payment, we cannot guarantee your exact insurance coverage. Your deductible and estimated portion are due at the time services are rendered; this includes any children coming to appointments without parents. You may receive a statement with an additional balance after your insurance has paid the portion they decide to pay. Once the insurance carrier has paid, the remaining balance is still your responsibility.

We are always available to answer your questions and assist you in any way we can.

Thank you,

Dr. Van Huffel

I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for treatment performed on me and my dependents. It is my responsibility to notify the office of any changes in my insurance. I understand that <u>payment will be due on the day service is rendered, even if my child comes to the office without a parent.</u>

Sign Name	Print Name	Date

COVID-19 Patient Waiver

Dr. Van Huffel has the utmost concern for my health and safety. The guidelines from governing bodies are sometimes vague and conflicting and Dr. Van Huffel is working diligently to determine how to continue to care for patients while keeping the team and public as safe as possible. I understand that there is a real risk of being exposed to the COVID-19 when coming in contact with the general public. This can happen at the grocery store, gas station or other public place.

The Governor of Ohio, Ohio Dental Board, ADA, CDC and other agencies have issued guidelines to decrease risk. It is my personal responsibility to be aware of and follow these guidelines to protect myself and my family. I also understand that these guidelines are changing daily, and it is my personal responsibility to keep up on all of the changes and make my own decisions for my health and that of my family.

In the process of being treated in a dental office I am coming in contact with the general public. I am in close proximity or direct contact with a number of people throughout the visit that may have been exposed to the COVID-19 virus and may not be symptomatic. Dr. Van Huffel is taking every possible precaution, but there is no guarantee that I will not come in contact with someone who has the virus in this office. Dr. Van Huffel is implementing current guidelines to keep me safe. I understand that I am allowed to go home at any point if I do not feel safe. I will bring to Dr. Van Huffel's attention any procedure or situation that I feel increases the risk of transmission to others.

I have been given the option by Dr. Van Huffel to cancel or reschedule my appointment. There will be no negative consequences to my future relationship here if I choose to go home. By signing this form, I am stating that I have not had any flu symptom and I do not have a fever. I have not traveled to a high-risk area in the last 14 days or been in close contact with someone who has been diagnosed with or is under investigation for COVID-19 and/or if they have a cough, fever or shortness of breath.

By signing this form, I am choosing to be	e treated today and I accept the risks of being here.
	Printed Name
	Signature
	Date