Complete Health
Dentistry of Columbus

A partnership in dentistry and medicine

350 W. Wilson Bridge Rd., Suite 320 • Worthington, OH 43085
Phone: 614.885.3602 • Fax: 614.885.6085 • www.mcclatchiedds.com

FINANCIAL POLICY

Welcome and thank you for choosing Barbara McClatchie DDS, Complete Health Dentistry of Columbus! Our primary mission is to deliver comprehensive dental care that fits in your lifestyle An important part of our mission is making the cost of optimal cares as easy and manageable for our patients by offering several payment options.

INSURANCE

Our practice welcomes all insurance plans. We will do a complimentary benefits check at your first visit but please bring your insurance information with you to all of your appointments. For your convenience, we will be happy to submit insurance claims on your behalf to your insurance company. However, please remember, your insurance policy is a written contract between you and your insurance company and it is the your responsibility to understand the coverage and benefits provided. We will do our best to provide you with accurate estimates for treatment and will try to utilize the full benefits of your policy. However, please know that you are responsible for any portion of services your insurance may not cover and we require payment of that amount on the day of service. If you have any questions, our business team will be happy to assist you.

PAYMENTS

All payments are due at the time of service, unless prior arrangements have been made.
We accept cash, check, Visa, MasterCard, Discover Card, and CareCredit.
Generously, Dr McClatchie does offer a **5% "pay today"** courtesy for all treatment that is presented that day.

CANCELLATION/BROKEN APPOINTMENT POLICY

If you are unable to keep your scheduled appointment, we ask for at least 48 hours notice, so that we may provide your reserved time to another patient. Failure to provide us with adequate notice will result in a $25.00/hr charge if you miss more than one appointment in a calendar year. A $35.00 fee will be applied for any returned check. Any accounts outstanding more than 30 days will accrue a $5.00 rebilling charge per month.

Patient, Parent or Guardian Signature Date

Patient Name (Please print)

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We are pleased to welcome you into our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help. We look forward to helping you maintain your dental and overall health.

Name _____ Soc. Sec. #_____
(LAST) (FIRST) (M)

Address _____
(STREET) (CITY) (STATE) (ZIP)

Cell Phone _____ Home Phone _____ Work Phone _____

Sex Male Female Email_____

How did you hear about us?_____

***We love to thank current patients for referrals**

Are you in pain?

☐ Yes ☐ No

Where is the pain located? (Please be specific)	When was your last dental visit?
Does it keep you up at night?	How would you rate your previous dental care?
On a scale from 1-10, 10 being the worst pain, how bad is your pain?	Why are you changing dentists?
How long has it been bothering you?	How happy are you with your smile?
Is it sensitive to hot or cold?	What would you like to achieve long-term with your smile?
What makes it worse?	What would you like to convey to us?
Would you like your whole mouth evaluated for long-term care?	Are there any special accomodations you need?

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Primary Insurance

Policy Holder _____ D.O.B. _____

Insurance Company _____ Soc. Sec. #_____

Address _____
(STREET) (CITY) (STATE) (ZIP)

Employer _____ Group # _____ Alt # _____

Additional Insurance

Is the patient covered by additional insurance? ☐ Yes ☐ No (If no, skip section)

Policy Holder _____ D.O.B. _____

Insurance Company _____ Soc. Sec. #_____

Address _____
(STREET) (CITY) (STATE) (ZIP)

Employer _____ Group # _____ Alt # _____

We thank you for your time and willingness in completing this form so we can better treat you as the individual you are. We look forward to speaking with you and meeting you in Dr. McClatchie's office.

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SMILE EVALUATION FORM

Your smile affects your self-image, and can greatly influence the quality of your interactions with others. Many people hold back from laughing or smiling because they are uncomfortable with their smile. The following questions are designed to honestly appraise your smile.

Go to a mirror, smile as wide as you can, and ask yourself the following questions:

Are any of your teeth yellow, stained or somewhat discolored?	☐ Yes	☐ No
Would you like your teeth to be whiter?	☐ Yes	☐ No
Do you have any gaps or spaces between your teeth?	☐ Yes	☐ No
Are any of your teeth turned, crooked, or uneven?	☐ Yes	☐ No
Are you missing any teeth?	☐ Yes	☐ No
Are there any foods you are unable to eat comfortably?	☐ Yes	☐ No
Do you see any pitting or defects on the surfaces of your teeth?	☐ Yes	☐ No
Are the edges of any teeth worn down, chipped or uneven?	☐ Yes	☐ No
Do any of your teeth appear too small, short, large or long?	☐ Yes	☐ No
Do you have any prior dental work that appears unnatural?	☐ Yes	☐ No
Do you have any crowns or bridges that appear dark at the edge of your gums?	☐ Yes	☐ No
Do you have any gray, black or silver (mercury) fillings in your teeth?	☐ Yes	☐ No
Do you have a "gummy" smile (too much of your gums show when smiling)?	☐ Yes	☐ No
Are your gums red, sore, puffy, bleeding or receded?	☐ Yes	☐ No
Does the appearance of your smile inhibit you from laughing or smiling?	☐ Yes	☐ No
When being photographed, do you smile with your lips closed instead of flashing a full smile?	☐ Yes	☐ No
Are you self-conscious about your teeth or smile?	☐ Yes	☐ No

If you have checked "Yes" to one or more of the above questions contact our office for a cosmetic simulation. Let us show you how YOU could look with a more attractive smile.

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part 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? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: 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	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
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 ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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Name _____

Due to the oral systemic connection, it is important I be your advocate and contact your primary care physician and all other health care providers when applicable.

Please complete the information below so we can work together to ensure we provide you the best overall care.

	Provider	Phone	Address
Primary physician			
Cardiologist			
Orthopedic			
Internist			
OB/Gyn			
Endocrinologist			
Oncologist			
Neurologist			
Sleep physician			
Ear Nose and Throat			
Pulmonologist			

The Heart Attack & Stroke Prevention Center of Central Ohio

Complete Health Dentistry of Columbus

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date_____

Print Patient Name _____

Signature _____

Relationship to Patient _____

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&
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