SCARLET DENTAL, KATIE VINCER SEARS DDS, INC.

Tel: 614-829-7703

107 W. COLUMBUS ST.
PICKERINGTON, OH 43147

PATIENT INFORMATION

Date: ☐ NEW PATIENT ☐ UPDATE

Patient:

LAST FIRST MI PREFERRED TITLE

☐ MALE ☐ FEMALE ☐ CHILD* ☐ STUDENT** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐ FULL-TIME ☐ PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

HOME:
CELL:
OTHER:
PAGER:
FAX:

E-Mail:

Referral? ☐ Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP

Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

WORK: X
DIRECT:
OTHER:
PAGER:
FAX:

E-Mail:

INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

Scarlet DENTAL
Katie Vincer Sears DDS, Inc.
PICKERINGTON, OH
ZANESVILLE, OH

SCARLET DENTAL, KATIE VINCER SEARS DDS, INC.

Tel: 614-829-7703

107 W. COLUMBUS ST.
PICKERINGTON, OH 43147

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? .....
☐Y☐N Any serious illnesses/surgeries? .....
☐Y☐N Use tobacco in any form? If Yes, Type: .....
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: .....

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

.....

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

.....

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CHICKEN POX
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT EAR INFECTIONS
☐FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐PACEMAKER
☐OTHER – PLEASE LIST: .....
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐OTHER – PLEASE LIST:
☐CODEINE
☐DAIRY
☐LATEX
☐LACTOSE INTOLERANCE
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SLEEPING PILLS
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS
☐NONE

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

Financial Guidelines

Insurance

As a courtesy to out patients, we are happy to file your dental insurance claims. Dental insurance is not like medical coverage and rarely covers the same percentage. Your dental insurance is a contract between your employer and your insurance company. The professional treatment and dental services offered by Scarlet Dental is for your best oral health and will not be dictated by insurance coverage.

You are responsible for the deductible and percentage not covered by insurance for the work performed on the day of service. Fees are due at the time of service and any remaining balance that remains after the insurance company pays is due within 30 days of the date billed to the patient. We will always do our best to help you maximize your dental benefits; however, ultimately it is the patient's responsibility for payment.

Informed Consent

- I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.
- Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible medications.
- I agree to be responsible for all payments of any and all services rendered on my behalf of my dependents. I understand that payment is due at the time of service. If required, I also understand that a check of my credit history may be made. I also understand that any returned check or insufficient payments will be assessed a $35 fee and the entire balance will be paid immediately.
- I understand that if my account is sent to collections and my balance is paid in full, I am responsible for paying all future appointments at the date of service before insurance is billed.
- I agree that in the event this account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, cost, expense and court costs incurred in the collection of this account.
- I understand that if I cancel an appointment with less than 48 hours notice, there may be a failed appointment fee of $50 which I agree to pay before further appointments can be rescheduled.
- I acknowledge that I received a copy of the Scarlet Dental's Notice of Privacy Practices.

Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

By signing below I acknowledge I have read and understand the guidelines above.

Signature:_____ Date:

_____ _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)