



Magnolia
DENTAL

WWW.MYMAGNOLIASMILE.COM

11 Medical Drive
Chillicothe, OH 45601
740-775-8050 ph 740.775.8053 fax

Welcome To Our Practice! Serving You Exceptional Care with Southern Hospitality

Patient Information

Date: _____

Patient Name _____ SS# _____ Birthdate ____/____/____
Last Name First Name

Gender ☐ M ☐ F Age _____ Nickname _____

Home Phone _____ Cell _____ Email Address _____

Mailing Address _____
Street City State Zip

How did you hear about our practice? _____ Friend's Name (if Applicable) _____

Emergency Contact _____ Phone Number _____

Responsible Party

Name of person responsible for this account (if someone other than yourself) _____
Last Name First Name

Relationship _____ DL# _____ SS# _____ Birthdate ____/____/____

Home Phone _____ Cell _____ Email Address _____

Address _____
Street City State Zip

Employer _____ Work Phone _____

Is this patient currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Primary

Do you have insurance to assist you with payment? ☐ Yes ☐ No

Name of Insured _____

Relationship _____ SS# _____

Birthdate ____/____/____ Work Phone _____

Employer _____

Employer Address _____

Insurance Company _____ Group # _____

Do you have a deductible? ☐ Yes ☐ No ☐ I'm not sure

Do you know your maximum annual benefit? ☐ Yes Amount \$ _____ ☐ No

Have you used this insurance at a dental practice before? ☐ Yes ☐ No

Secondary

Do you have insurance to assist you with payment? ☐ Yes ☐ No

Name of Insured _____

Relationship _____ SS# _____

Birthdate ____/____/____ Work Phone _____

Employer _____

Employer Address _____

Insurance Company _____

Do you have a deductible? ☐ Yes ☐ No ☐ I'm not sure

Do you know your maximum annual benefit? ☐ Yes Amount \$ _____ ☐ No

Have you used this insurance at a dental practice before? ☐ Yes ☐ No



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Medical History

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? _____
Are you on a special diet? _____
Do you use tobacco? _____
Do you use controlled substances? _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Women Only: Are you: Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking Oral Contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Do you have or have you had any of the following?

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortizone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weights Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
						Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Comments & Signature

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 Magnolia Dental of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____



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Practice Financial Policy

We are committed to providing you and your family with the best possible care and are pleased to discuss our professional fees with you at any time, and your insurance coverage, with you at any time. Your clear understanding of our financial and insurance policies is important to our relationship. Please ask us, at any time, if you have any questions about this policy.

- All patients must complete and sign the Patient Registration and History form before seeing the Doctor.
- We accept most insurance plans and will gladly process your claim. Please notify us of any changes in your insurance plan and bring your current insurance card to each visit. Insurance policies generally cover only a portion of the total treatment cost. *Unless other arrangements have been made, we ask that you pay your portion of the bill at the time of treatment. It is your responsibility to pay any balance not paid by your insurance company.*
- For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover, and American Express. Financing is also available through Care Credit.
- Twenty-four hour notice is required when re-scheduling or canceling an appointment. A cancellation fee of \$25.00 may be assessed for broken appointments with less than twenty-four hour notice.
- Treatment plans may change, and you will be responsible for the treatment actually completed.
- For your convenience, this office may release your information to your insurance company, and receive payment directly from them. Every effort will be made to help you with your insurance, however, the insurance company, not our office, determines the dental benefits that you receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges are your responsibility. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.
- If sent to collections, you understand that it is your full financial responsibility to pay all court costs and all collection fees and/or attorneys fees.

I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors. I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I am responsible for payment regardless of insurance company's arbitrary determination of reasonable and customary rates. I understand that payment is expected when services are rendered unless other arrangements are made in advance.

Patient Name _____ Birthdate ____/____/____

Signature of Parent or Guardian Date: _____

Patient Habits

Although you may not be aware, many common habits can affect your oral health. Please take a moment to review the chart below and indicate which box reflects your habits. Your honesty is important and, as always, your responses will remain confidential.

Habit	I do this now	I used to do this	How long?	How much?	I don't do this
Grind your teeth					
Bite or chew your cheek					
Bulimia Anorexia					
Smoke cigar or Cigarettes					
Smoke pipe					
Chew tobacco					
Bite nails					
Suck thumb or finger					
Use a toothpick or stimulator					
Chew gum					
Eat candy					
Soft drinks					
Crunch hard foods (like popcorn)					
Chew ice					
Suck on mints or candies					
Use recreational drugs					