INFINITY
DENTAL

PATIENT REGISTRATION

First Name: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Home #: _____ Cell #: _____ Preferred Contact #: ☐ HOME or ☐ CELL

Work #: _____ Ext: _____ Email Address: _____

Birthdate: _____ Social Security#: _____ Driver's License #: _____

Emergency Contact: _____ Phone Number: _____

RESPONSIBLE PARTY (if someone other than the patient)

First Name: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Home #: _____ Cell #: _____ Preferred Contact #: ☐ HOME or ☐ CELL

Work #: _____ Ext: _____ Email Address: _____

Birthdate: _____ Social Security#: _____ Driver's License #: _____

Emergency Contact: _____ Phone Number: _____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Sec. #: _____ Insured DOB: _____ Employer: _____

Insurance Company: _____ Contact Number: _____

Claims Mailing Address: _____ City, State, Zip: _____

Thank you so much for filling out these forms.
It will help us provide you with the best possible care.

INFINITY DENTAL

Patient Name: _____ **Birth Date:** _____ **Date Created:** _____

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** _____
Have you ever been hospitalized or had a major operation?	☐ **Yes** ☐ **No**	**If Yes** _____
Have you ever had a serious head or neck injury?	☐ **Yes** ☐ **No**	**If Yes** _____
Are you taking any medications, pills, or drugs?	☐ **Yes** ☐ **No**	**If Yes** _____
Do you take, or have you taken, Phen - Fen or Redux?	☐ **Yes** ☐ **No**	**If Yes** _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ **Yes** ☐ **No**	**If Yes** _____
Are you on a special diet?	☐ **Yes** ☐ **No**	**If Yes** _____
Do you use tobacco?	☐ **Yes** ☐ **No**	**If Yes** _____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other? If Yes _____

Do you use controlled substances? ☐ Yes ☐ No If Yes _____

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**	Easily Winded ☐ **Yes** ☐ **No**	Hepatitis B or C ☐ **Yes** ☐ **No**	Renal Dialysis ☐ **Yes** ☐ **No**
Anemia ☐ **Yes** ☐ **No**	Emphysema ☐ **Yes** ☐ **No**	Herpes ☐ **Yes** ☐ **No**	Rheumatic Fever ☐ **Yes** ☐ **No**
Angina ☐ **Yes** ☐ **No**	Epilepsy or Seizures ☐ **Yes** ☐ **No**	High Blood Pressure ☐ **Yes** ☐ **No**	Rheumatism ☐ **Yes** ☐ **No**
Arthritis/Gout ☐ **Yes** ☐ **No**	Excessive Bleeding ☐ **Yes** ☐ **No**	High Cholesterol ☐ **Yes** ☐ **No**	Scarlet Fever ☐ **Yes** ☐ **No**
Artificial Heart Valve ☐ **Yes** ☐ **No**	Excessive Thirst ☐ **Yes** ☐ **No**	Hives or Rash ☐ **Yes** ☐ **No**	Shingles ☐ **Yes** ☐ **No**
Artificial Joint ☐ **Yes** ☐ **No**	Fainting Spells/ Dizziness ☐ **Yes** ☐ **No**	Hypoglycemia ☐ **Yes** ☐ **No**	Sickle Cell Disease ☐ **Yes** ☐ **No**
Asthma ☐ **Yes** ☐ **No**	Frequent Cough ☐ **Yes** ☐ **No**	Irregular Heartbeat ☐ **Yes** ☐ **No**	Sinus Trouble ☐ **Yes** ☐ **No**
Blood Disease ☐ **Yes** ☐ **No**	Frequent Diarrhea ☐ **Yes** ☐ **No**	Kidney Problems ☐ **Yes** ☐ **No**	Spina Bifida ☐ **Yes** ☐ **No**
Blood Transfusion ☐ **Yes** ☐ **No**	Frequent Headaches ☐ **Yes** ☐ **No**	Leukemia ☐ **Yes** ☐ **No**	Stomach/Intestinal Disease ☐ **Yes** ☐ **No**
Breathing Problems ☐ **Yes** ☐ **No**	Genital Herpes ☐ **Yes** ☐ **No**	Liver Disease ☐ **Yes** ☐ **No**	Stroke ☐ **Yes** ☐ **No**
Bruise Easily ☐ **Yes** ☐ **No**	Glaucoma ☐ **Yes** ☐ **No**	Low Blood Pressure ☐ **Yes** ☐ **No**	Swelling of Limbs ☐ **Yes** ☐ **No**
Cancer ☐ **Yes** ☐ **No**	Hay Fever ☐ **Yes** ☐ **No**	Lung Disease ☐ **Yes** ☐ **No**	Thyroid Disease ☐ **Yes** ☐ **No**
Chemotherapy ☐ **Yes** ☐ **No**	Heart Attack/Failure ☐ **Yes** ☐ **No**	Mitral Valve Prolapse ☐ **Yes** ☐ **No**	Tonsillitis ☐ **Yes** ☐ **No**
Chest Pains ☐ **Yes** ☐ **No**	Heart Murmur ☐ **Yes** ☐ **No**	Osteoporosis ☐ **Yes** ☐ **No**	Tuberculosis ☐ **Yes** ☐ **No**
Cold Sores/Fever Blisters ☐ **Yes** ☐ **No**	Heart Pacemaker ☐ **Yes** ☐ **No**	Pain in Jaw Joints ☐ **Yes** ☐ **No**	Tumors or Growths ☐ **Yes** ☐ **No**
Congenital Heart Disorder ☐ **Yes** ☐ **No**	Heart Trouble/Disease ☐ **Yes** ☐ **No**	Parathyroid Disease ☐ **Yes** ☐ **No**	Ulcers ☐ **Yes** ☐ **No**
Convulsions ☐ **Yes** ☐ **No**	Convulsions ☐ **Yes** ☐ **No**	Psychiatric Care ☐ **Yes** ☐ **No**	Venereal Disease ☐ **Yes** ☐ **No**
			Yellow Jaundice ☐ **Yes** ☐ **No**

Have you ever had any serious illness not listed ☐ Yes ☐ No If Yes _____

Comments:

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

Signature of Patent, Parent or Guardian: _____ **Date:** _____

INFINITY DENTAL

Infinity Dental

1234 Old Henderson Rd # A,
Columbus, OH 43220

614-268-9443

Thank you for choosing Infinity Dental for your dental needs. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- **Cash or Check**
  *5% courtesy accounting adjustment to patients who pay in full for their treatment PRIOR to completion of care
- **Visa, MasterCard, Discover or American Express**
- **Convenient monthly payment options from Care Credit's healthcare credit card**
  *No annual fees or prepayment penalties
  *6 months interest free for treatment plans under $1,000
  *12 months interest free for treatment plans over $1,000
  *Extended low monthly payment plans are also available up to 60 months with a low interest rate of 14.9%

Please note:

Infinity Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For larger, more comprehensive treatment plans of $4,000 or more, a 10% deposit is required to secure your initial appointment (the deposit will go toward your treatment). **Please keep in mind we are reserving a large part of our day for you and in the event that a cancellation is made without 7 days notice your deposit will be forfeited.**

For patients with dental insurance--we are happy to work with your carrier to maximize your benefits. As a courtesy, we will estimate an out of pocket portion, but please keep in mind that all quotes are just an estimate and we cannot guarantee insurance payments. If your insurance does not pay as expected any remaining balance will be your responsibility.

We charge $50 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the care you want or need.

Name (please print)	Patient, Client, Parent or Guardian Signature	Date

If you would like a copy for your records, please ask a staff member.

INFINITY DENTAL

Infinity Dental
1234 Old Henderson Rd # A,
Columbus, OH 43220
614-268-9443

HIPAA PRIVACY AUTHORIZATION FORM

Date: _____

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITIED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

Patient name(s) **(please print)** _____ **Signature** of patient, parent or guardian _____

Please list any other parties who can have access to your health information (this includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

I authorize contact from this office to confirm my appointments, treatment & billing information via:

- ☐ Cell phone confirmation
- ☐ Work phone confirmation
- ☐ mail Confirmation
- ☐ Home phone confirmatio
- ☐ Text message to my cell phone
- ☐ **Any of the above**

I authorize information about my health be conveyed via:

- ☐ Cell phone confirmation
- ☐ Work phone confirmation
- ☐ mail Confirmation
- ☐ Home phone confirmatio
- ☐ Text message to my cell phone
- ☐ **Any of the above**

I approve being contacted about special services, events, fund raising efforts or new health info on behalf of this Healthcare Facility via:

- ☐ Phone message
- ☐ Email
- ☐ **None of the above** (opt out)
- ☐ Text message
- ☐ **Any of the above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office use only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this acknowledgement but did not because:

- It was emergency treatment ☐
- I could not communicate with the patient ☐
- The patient refused to sign ☐
- The patient was unable to sign because ☐
- Other (please describe) ☐ _____

Signature of Privacy Officer: _____