Patient Information

Name: _____ **DOB:** _____

Parent or Guardian:_____

Phone Number:_____ **Are you OK receiving texts messages? Yes/No**

Email:_____

Address:_____ **City:**_____**State:**_____**Zip:**_____

Emergency Contact:_____ **Phone Number:**_____

Relationship:_____

Who can we thank for referring you?_____

Insurance Information

Policy Holder's Name:_____
Policy Holder's DOB:_____
Policy Holder's SSN:_____
Policy Holder's Address:
_____
Policy Holder's Phone Number:
_____
Policy Holder's Employer (If benefits are through an employer):
_____

Dental Insurance Company:
_____
ID Number:
_____
Group Number:
_____
Phone Number on the back of your insurance card:_____
Address on the back of your insurance card:
_____

Secondary Insurance Information (if applicable)

Policy Holder's Name:_____
Policy Holder's DOB:_____
Policy Holder's SSN:_____
Policy Holder's Address:
_____
Policy Holder's Phone Number:
_____
Policy Holder's Employer (If benefits are through an employer):
_____

Dental Insurance Company:
_____
ID Number:
_____
Group Number:
_____
Phone Number on the back of your insurance card:_____
Address on the back of your insurance card:
_____

Health History

COLUMBIA HEALTHY SMILES

Name: _____ Date: _____

Are you currently under the care of a physician? **Yes/No**

Physician:_____

Office Phone:_____

Date of Last exam:_____

Have you ever been hospitalized for any serious illness within the last 5 years? **Yes/No**
If yes, please explain.

_____

_____

Are you taking any medication(s) including non-prescription medication? **Yes/No**
If yes, what are you taking?

_____

_____

Have you ever taken Fen-Phen/Redux? **Yes/No**
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? **Yes/No**
Have you ever taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours? **Yes/No**
Do you use tobacco? **Yes/No**
Do you use controlled substances? **Yes/No**
Are you wearing contact lenses? **Yes/No**

Do you have a persistent cough or throat clearing not associated with any known illness lasting more than 3 weeks? **Yes/No**

Women only:

Are you pregnant or think you may be pregnant? **Yes/No**
Are you nursing? **Yes/No**
Are you taking oral contraceptives? **Yes/No**

Are you allergic to or have any reactions to the following?

- ☐ Local Anesthetics
- ☐ Penicillin or any other Antibiotics
- ☐ Sulfa Drugs
- ☐ Barbiturates
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Any Metals (nickel, etc.)
- ☐ Latex Rubber
- ☐ Other

(Please List)_____

Please continue on back

Do you have or have had any of the following?

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Alzheimer's/Dementia	☐	☐	Stomach Troubles/Ulcers	☐	☐
Heart Attack	☐	☐	Autism	☐	☐	Chest Pains	☐	☐
Rheumatic Fever	☐	☐	Psychiatric Conditions	☐	☐	Easily Winded	☐	☐
Swollen Ankles	☐	☐	Heart Disease	☐	☐	Stroke	☐	☐
Fainting/Seizures	☐	☐	Cardiac Pacemaker	☐	☐	Hay Fever/Allergies	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐
Low Blood Pressure	☐	☐	Angina	☐	☐	Radiation Therapy	☐	☐
Epilepsy/Convulsions	☐	☐	Frequently Tired	☐	☐	Glaucoma	☐	☐
Leukemia	☐	☐	Anemia	☐	☐	Recent Weight Loss	☐	☐
Diabetes	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐
Kidney Diseases	☐	☐	Cancer	☐	☐	Heart Trouble	☐	☐
AIDS or HIV Infection	☐	☐	Arthritis	☐	☐	Respiratory Problems	☐	☐
Thyroid Problem	☐	☐	Joint Replacement or Implant	☐	☐	Mitral Valve Prolapse	☐	☐
Anxiety	☐	☐	Hepatitis/Jaundice	☐	☐	Other _____	☐	☐
Depression	☐	☐	Sexually Transmitted Disease	☐	☐			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing false 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 myself or my child during the period of such dental care to third party payors and/or health practitioners.

_____

Signature of Patient (or parent/guardian if minor) **Date**

Dental History

COLUMBIA HEALTHY SMILES

Name: _____ Date: _____

Previous Dentist:_____ **Office Address:**_____

Office Phone:_____ **Date of Last exam:**_____

Do your gums bleed while brushing or flossing? **Yes/No**

Are your teeth sensitive to hot or cold liquids/foods? **Yes/No**

Are your teeth sensitive to sweet or sour liquids/foods? **Yes/No**

Do you feel pain in any of your teeth? **Yes/No**

Do you have any sores or lumps in or near your mouth? **Yes/No**

Have you had any head injuries? **Yes/No**

Do you have frequent headaches? **Yes/No**

Do you clench or grind your teeth? **Yes/No**

Do you bite your lips or cheeks frequently? **Yes/No**

Have you experienced any of the following problems in your jaw?

- ☐ Clicking
- ☐ Pain (joint, ear, side of face)
- ☐ Difficulty opening or closing
- ☐ Difficulty chewing

Have you ever had any difficult extractions in the past? **Yes/No**

Have you ever had any prolonged bleeding following extractions? **Yes/No**

Have you had any orthodontic treatment? **Yes/No**

Do you wear dentures or partials? **Yes/No**

If yes, date of placement:_____

Have you ever had oral hygiene instructions regarding the care of your teeth and gums? **Yes/No**

Do you like your smile? **Yes/No**

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing false 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 myself or my child during the period of such dental care to third party payors and/or health practitioners.

_____

Signature of Patient (or parent/guardian if minor) **Date**

Philip A. Batson, D.D.S. & Elizabeth Abe, D.D.S.
2516 Forum Blvd. Ste. 200
Columbia, MO 65203
P: 573-875-7071 F: 573-875-7072

Records Release Request Form

Patient Name:_____ **DOB:** _____

I, _____, wish to have my dental records transferred from

Office: _____

Address: _____

Phone:_____ Email: _____

Please forward all radiographs electronically to **info@columbiahealthysmiles.com.**

If x-rays are not digital or you are unable to email x-rays, please mail diagnostic quality images to:

Columbia Healthy Smiles

2516 Forum Blvd. Ste. 200

Columbia, MO 65203

This authorization is effective until I cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Signed: _____ Date: _____

Patient (Parent/Legal Guardian if minor)

OFFICE Financial Policy

COLUMBIA HEALTHY SMILES
Dr. Philip Batson & Dr. Elizabeth Abe
2516 Forum Blvd. Ste. 200 Columbia, MO 65203
573-875-7071

Payment is due at the time services are rendered. For your convenience we accept cash, Visa, Mastercard, personal check, money order, or registered check.

Insurance benefits are determined by your employer and not your dentist. **Any deductible or estimated co-payment amount will be due at the time of treatment.** Insurance is not a guarantee of payment; insurance companies will not pay for all your costs. Your insurance policy is a contract between you and your insurer. Your insurance and payment are still your responsibility. As a courtesy we will be glad to file your claim for you if you bring 1) your dental insurance wallet card, and 2) all required employer information. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment.

We reserve the right to charge and collect fees for broken appointments – appointments that are canceled or broken without 48-hours advance notice. Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Returned Check Fee of $35.00 will be added to your account balance and is collectible.

Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment.

Minor Patients: The parent or guardian accompanying the minor is responsible for the full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

Courtesies cannot be combined and are not to exceed 5%. (With the exception of the Healthy Smiles Plan.)

I have read and understand this financial policy.

Printed Name:_____ **Date:**_____

Signature:_____

COLUMBIA HEALTHY SMILES

PHILIP A. BATSON, D.D.S. & ELIZABETH ABE, D.D.S.
2516 FORUM BLVD. STE. 200
COLUMBIA, MO 65203
P: 573-875-7071 F: 573-875-7072

Appointment Policy

We do our best to respect our patient's time. We ask that you only make appointments you can and will keep.

If you need to change a scheduled appointment, please give us at least 48 hours notice so that we can make this time available to other patients.

Deposits may be collected to reserve time and are non-refundable if adequate notice is not provided to reschedule. This deposit will go toward a patient's account balance given no conflicts.

We reserve the right to charge a $50 per hour missed appointment fee for scheduled appointments that are not kept or for patients who present with a history of broken appointments or late cancellations.

COVID-19 exception for those who have been tested or are under direct orders to quarantine.

If you anticipate problems in keeping your scheduled appointments due to any circumstance, please ask about our VIP scheduling.

Please show up on time for your appointments. If you are late it directly affects our schedule for the day and other patients' appointments and may cause your appointment to be rescheduled. If this is the case we may consider this a missed appointment and the missed appointment fee would apply.

If there is a consistent issue with keeping scheduled appointments Columbia Healthy Smiles may not be a good fit and we would recommend seeking care elsewhere.

Signature: _____ Date: _____

COLUMBIA HEALTHY SMILES

PHILIP A. BATSON, D.D.S. & ELIZABETH ABE, D.D.S.
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COLUMBIA, MO 65203
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Privacy Policy

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 2516 Forum Blvd Ste. 200 Columbia, MO 65203.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed healthcare professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a

medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual’s dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

9. SUD Treatment Information. If we receive or maintain any information about you from a substance abuse disorder treatment program that is covered by 42 CFR Part 2 (a “Part 2 Program”) through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment, or health care operations, we may use and disclose your Part 2 Program record for treatment, payment, and health care operations purposes as described in this notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

I certify that I have read and understand the above information to the best of my knowledge.

Signature: _____ Date: _____