





## **Patient Information**

Sex:       DOB:       /       SSN:       -       -       Image: Single III Minor         Preferred Method of Contact:       Email:       Zip:       Zip: </th <th>First Name:</th> <th> Last Name:</th> <th>Preferred</th> <th colspan="2"> Preferred Name:</th>	First Name:	Last Name:	Preferred	Preferred Name:						
Phone: { )	Sex: DOB:	_/ / SSN: _		Married 🗆 Single 🗆 Minor						
Preferred Method of Contact:      Email      Phone Call      Text Message Home Address:     City:     State:     Zip:     Timor, provide parent/guardian information:     Porent/Guardian Name:     DOB:     //SSN:  How did you hear about us?     Medical History Physician's Name:     Phone:     / Phone:     / Have you ever had a blood transfusion?     Yes      No     If yes, When?     / Have you ever taken the group of drugs collectively referred to as "Fen-Phen"?     These include     combinations of Lonimin, Adipex, Fastin, Pondimin, and Redux?     Yes      No     Are you ever taken the group of drugs collectively referred to as "Fen-Phen"?     These include     combinations of Lonimin, Adipex, Fastin, Pondimin, and Redux?     Yes      No     Are you pregnant?     Cough - Persitent     Athintis, Rheumatism     Cough - Persitent     HW/AIDS     Artificial Heart Valves     Diabetes     Kiney Disease     Weelling of Feet or Ankles     Artificial Heart Valves     Diabetes     Glaucoma     Hard Mumur     Radiation Treatment     Ulcers     Scale Problems     Glaucoma     Fanifung     Middi Valve Prolapse     Tobacco Habit     Bood Disease     Heart Mumur     Radiation Treatment     Ulcers     Cortisone Disease     High Blood Pressure     Cortisone Disease     High Blood Pressure     Corteck If You Have Any of the Following Allergies:     Aspin     Codeine     Latex     Local Anesthetic     Current Weight:  Pharmacy Name:     Latex     Local Anesthetic     Diabetist:     Codeine     Latex     Local Anesthetic     Diabetist:     Corteck If You Have Any of the Following Allergies:     Application You are Currently Taking:				-						
Home Address:										
If minor, provide parent/guardian information: Parent/Guardian Name:DOB:// SSN:, How did you hear about us?	Home Address:		_ City:	State: Zip:						
Parent/Guardian Name:       DOB:       /				·						
Medical History         Physician's Name: Phone: ( )				SSN:						
Medical History         Physician's Name:										
Date of Last Visit       //										
Date of Last Visit       //	Physician's Name:	Phone	: ( )							
Have you ever had a blood transfusion? □ Yes □ No       If yes, When?/         Have you ever taken the group of drugs collectively referred to as "Fen-Phen"? These include combinations of Lonimin, Adipex, Fastin, Pondimin, and Redux? □ Yes □ No         Are you pregnant? □ Yes □ No       Nursing? □ Yes □ No         Taking Birth Control? □ Yes □ No         Check If You Have Any of the Following Conditions:         Anemia       □ Cough - Persistent         Intrificial Heart Valves       □ Diabetes         Artificial Joints       □ Epilepsy         Introl Are you pregnant?       □ Gough - Persistent         Introl Are you and the pollowing Conditions:       □ Skin Rash         Antificial Joints       □ Epilepsy         Introl Are you and the pollowing Conditions:       □ Skin Rash         Artificial Joints       □ Epilepsy         Isocher       □ Skin Rash         Blood Disease       □ Feinting         Isocher       □ Readaches         Chemical Dependency       □ Heart Problems         Isocher       □ Heart Problems         Isocher       □ Heapatilis         Isocher       □ Heigh Blood Pressure         Isocher       □ Heigh Blood Pressure         Chemical Dependency       □ Heart Problems         Isopentalex       □ Scarlet Fever										
combinations of Lonimin, Adipex, Fastin, Pondimin, and Redux? Yes No Are you pregnant? Yes No Nursing? Yes No Taking Birth Control? Yes No Check If You Have Any of the Following Conditions: Anemia Cough - Persistent HIV/AIDS Skin Rash Arthritis, Rheumatism Cough up Blood Jaw Pain Stroke Artificial Heart Valves Diabetes Kidney Disease Swelling of Feet or Ankles Artificial Joints Epilepsy Liver Disease Tobacco Habit Back Problems Glaucoma Pacemaker Tonsilitis Blood Disease Headaches Pregnancy Tuberculosis Chemical Dependency Heart Problems Respiratory Treatment Ulcers Carcer Heart Murmur Radiation Treatment Ulcers Carcer Heart Murmur Radiation Treatment Ulcers Carcisone Disease Heapatitis Scarlet Fever Cortisone Disease High Blood Pressure Shortness of Breath List Medications You are Currently Taking: Pharmacy Name: Zip Code: Current Weight: Libs. Check If You Have Any of the Following Allergies: Aspirin Penicillin Penicillin Barbiturates (Sleeping Pills) Sulfa Codeine Latex Following Allergies: Aspirin Penicillin Barbiturates (Sleeping Pills) Sulfa Codeine Latex Former Dentist:			□ No If yes, Whe	en? / /						
Are you pregnant?       I Yes       No       Nursing?       Yes       No       Taking Birth Control?       Yes       No         Check If You Have Any of the Following Conditions:       Anemia       Cough - Persistent       HIV/AIDS       Skin Rash         Arthritis, Rheumatism       Cough up Blood       Jaw Pain       Stroke       Stwelling of Feet or Ankles         Arthriticial Heart Valves       Diabetes       Kidney Disease       Swelling of Feet or Ankles         Artificial Joints       Epilepsy       Liver Disease       Thyroid Problems         Back Problems       Glaucoma       Pacemaker       Tobacco Habit         Bock Problems       Glaucoma       Pregnancy       Tuberculosis         Cancer       Heart Murmur       Radiation Treatment       Ulcers         Chemotherapy       Heart Problems       Respiratory Treatment       Ulcers         Cortisone Disease       High Blood Pressure       Shortness of Breath       Venereal Disease         List Medications You are Currently Taking:	Have you ever taken t	he group of drugs colled	ctively referred to as "Fer	n-Phen"? These include						
Check If You Have Any of the Following Conditions: Anemia Anemia Cough - Persistent Cough up Blood Jaw Pain Stroke	combinations of Lonim	iin, Adipex, Fastin, Pondi	imin, and Redux? 🛛 🛛 Ye	es □ No						
<ul> <li>Anemia</li> <li>Cough - Persistent</li> <li>HIV/AIDS</li> <li>Skin Rash</li> <li>Arthritis, Rheumatism</li> <li>Cough up Blood</li> <li>Jaw Pain</li> <li>Stroke</li> <li>Arthritis, Rheumatism</li> <li>Cough up Blood</li> <li>Jaw Pain</li> <li>Stroke</li> <li>Stroke</li> <li>Stroke</li> <li>Arthritis, Rheumatism</li> <li>Cough up Blood</li> <li>Jaw Pain</li> <li>Stroke</li> <li>S</li></ul>	Are you pregnant? 🗆 Y	es 🗆 No 🛛 Nursing? 🗆 \	res □ No Taking Birth	Control? 🗆 Yes 🗆 No						
<ul> <li>Arthritis, Rheumatism</li> <li>Cough up Blood</li> <li>Jaw Pain</li> <li>Stroke</li> <li>Arthriticial Heart Valves</li> <li>Diabetes</li> <li>Kidney Disease</li> <li>Swelling of Feet or Ankles</li> <li>Arthriticial Joints</li> <li>Epilepsy</li> <li>Liver Disease</li> <li>Thyroid Problems</li> <li>Tobacco Habit</li> <li>Back Problems</li> <li>Glaucoma</li> <li>Pacemaker</li> <li>Tonsilitis</li> <li>Blood Disease</li> <li>Heart Murmur</li> <li>Radiation Treatment</li> <li>Ulcers</li> <li>Cancer</li> <li>Heart Murmur</li> <li>Radiation Treatment</li> <li>Ulcers</li> <li>Chemotherapy</li> <li>Heart Problems</li> <li>Respiratory Treatment</li> <li>Ulcers</li> <li>Cortisone Disease</li> <li>High Blood Pressure</li> <li>Shortness of Breath</li> <li>List Medications You are Currently Taking:</li> <li>Pharmacy Name:</li> <li>Catex</li> <li>Local Anesthetic</li> <li>Local Anesthetic</li> <li>Local Anesthetic</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Codeine</li> <li>Latex</li> <li>Local Anesthetic</li> <li>Local Anesthetic</li> <li>Local Anesthetic</li> <li>Local Anesthetic</li> <li>Check If You have concerns with any of the Following:</li> <li>Bad Breath</li> <li>Food Collection bw Teeth</li> <li>Periodontal Treatment</li> <li>Sensitivity to Sweets</li> <li>Beeding Gums</li> <li>Grinding Teeth</li> </ul>	Check If You Have Any	y of the Following Condi	tions:							
<ul> <li>Artificial Heart Valves</li> <li>Diabetes</li> <li>Kidney Disease</li> <li>Swelling of Feet or Ankles</li> <li>Artificial Joints</li> <li>Epilepsy</li> <li>Liver Disease</li> <li>Thyroid Problems</li> <li>Back Problems</li> <li>Glaucoma</li> <li>Pacemaker</li> <li>Tobacco Habit</li> <li>Back Problems</li> <li>Glaucoma</li> <li>Pregnancy</li> <li>Tuberculosis</li> <li>Cancer</li> <li>Heart Murmur</li> <li>Radiation Treatment</li> <li>Ulcers</li> <li>Chemical Dependency</li> <li>Heart Problems</li> <li>Respiratory Treatment</li> <li>Ulcers</li> <li>Chemotherapy</li> <li>Hemophilia</li> <li>Record Problems</li> <li>Cortisone Disease</li> <li>High Blood Pressure</li> <li>Shorthess of Breath</li> <li>List Medications You are Currently Taking:</li> <li></li> <li>Zip Code:</li> <li>Current Weight:</li> <li></li> <li>Dental History</li> <li>Reason for Today's Visit:</li> <li></li> <li>Date of Last Dental Visit:</li> <li></li></ul>		0								
<ul> <li>Artificial Joints</li> <li>Epilepsy</li> <li>Liver Disease</li> <li>Thyroid Problems</li> <li>Statkma</li> <li>Fainting</li> <li>Mitral Valve Prolapse</li> <li>Tobacco Habit</li> <li>Bload Disease</li> <li>Headaches</li> <li>Pregnancy</li> <li>Tuberculosis</li> <li>Cancer</li> <li>Heart Murmur</li> <li>Radiation Treatment</li> <li>Ulcers</li> <li>Chemical Dependency</li> <li>Heart Problems</li> <li>Respiratory Treatment</li> <li>Venereal Disease</li> <li>Heaphilia</li> <li>Rheumatic Fever</li> <li>Cortisone Disease</li> <li>High Blood Pressure</li> <li>Shortness of Breath</li> <li>List Medications You are Currently Taking:</li> <li></li> <li>Zip Code:</li> <li>Current Weight:</li> <li></li> <li>Pharmacy Name:</li> <li></li> <li>Zip Code:</li> <li>Codeine</li> <li>Latex</li> <li>Local Anesthetic</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Sulfa</li> <li>Codeine</li> <li>Latex</li> <li>Local Anesthetic</li> <li></li></ul>										
<ul> <li>Asthma</li> <li>Fainting</li> <li>Mitral Valve Prolapse</li> <li>Tobacco Habit</li> <li>Back Problems</li> <li>Glaucoma</li> <li>Pacemaker</li> <li>Tonsilitis</li> <li>Blood Disease</li> <li>Heard Mumur</li> <li>Radiation Treatment</li> <li>Ulcers</li> <li>Chemical Dependency</li> <li>Heart Problems</li> <li>Respiratory Treatment</li> <li>Ulcers</li> <li>Chemotherapy</li> <li>Hemophilia</li> <li>Repatitis</li> <li>Scarlet Fever</li> <li>Cortisone Disease</li> <li>High Blood Pressure</li> <li>Shortness of Breath</li> <li>List Medications You are Currently Taking:</li> <li>Pharmacy Name:</li> <li>Latex</li> <li>Dental History</li> <li>Reason for Today's Visit:</li> <li>Date of Last Dental Visit:</li> <li>/ Date of Last Dental X-Rays:</li> <li>/ Date of Last Dental X-Rays:</li> <li>/ Check If You have concerns with any of the Following:</li> <li>Bad Breath</li> <li>Food Collection btw Teeth</li> <li>Periodontal Treatment</li> <li>Sensitivity to Sweets</li> <li>Bleeding Gums</li> <li>Grinding Teeth</li> <li>Periodontal Treatment</li> <li>Sensitivity to Sweets</li> </ul>										
Blood Disease       Headaches       Pregnancy       Tuberculosis         Cancer       Heart Murmur       Radiation Treatment       Ulcers         Chemotherapy       Heart Problems       Respiratory Treatment       Venereal Disease         Chemotherapy       Heart Problems       Respiratory Treatment       Venereal Disease         Chemotherapy       Hepatitis       Scarlet Fever         Cortisone Disease       High Blood Pressure       Shortness of Breath         List Medications You are Currently Taking:				,						
Cancer <ul> <li>Cancer                 <ul> <li>Rediation Treatment                     <ul></ul></li></ul></li></ul>	Back Problems	🗆 Glaucoma	Pacemaker	🗆 Tonsilitis						
Chemical Dependency Heart Problems Respiratory Treatment Venereal Disease   Chemotherapy Hemophilia Rheumatic Fever   Circulatory Problems Hepatitis Scarlet Fever   Cortisone Disease High Blood Pressure Shortness of Breath   List Medications You are Currently Taking:   Pharmacy Name:   Pharmacy Name: Zip Code:   Check If You Have Any of the Following Allergies:   Aspirin Penicillin   Codeine Latex   Dental History   Reason for Today's Visit:   Date of Last Dental Visit:   /   Date of Last Dental Visit:   /   Date of Last Dental Visit:   /   Bad Breath   Bleeding Gums   Grinding Teeth Sensitivity to Cold Sensitivity when Biting										
Chemotherapy Hemophilia Rheumatic Fever   Circulatory Problems Hepatitis Scarlet Fever   Cortisone Disease High Blood Pressure Shortness of Breath   List Medications You are Currently Taking:										
Circulatory Problems Hepatitis   Cortisone Disease High Blood Pressure   Shortness of Breath   List Medications You are Currently Taking:   Pharmacy Name: Zip Code: Current Weight: Ibs. Check If You Have Any of the Following Allergies: Aspirin Penicillin Barbiturates (Sleeping Pills) Sulfa Codeine Latex Dental History Reason for Today's Visit:/ Date of Last Dental X-Rays:// Bed Breath Grinding Teeth Correct Sensitivity to Cold Sensitivity when Biting				U veneredi Disease						
Cortisone Disease     High Blood Pressure     Shortness of Breath List Medications You are Currently Taking:  Pharmacy Name:     Zip Code:     Current Weight:     Ibs. Check If You Have Any of the Following Allergies:     Aspirin     Penicillin     Penicillin     Penicillin     Barbiturates (Sleeping Pills)     Sulfa     Local Anesthetic   Reason for Today's Visit:  Pormer Dentist:  Former Dentist:  Date of Last Dental Visit:  Date of Last Dental Visit:  Check If You have concerns with any of the Following:     Bad Breath     Bleeding Gums     Grinding Teeth     Sensitivity to Cold     Sensitivity when Biting			🗆 Scarlet Fever							
Pharmacy Name:       Zip Code:       Current Weight:       Ibs.         Check If You Have Any of the Following Allergies:       Barbiturates (Sleeping Pills)       Sulfa         Aspirin       Penicillin       Barbiturates (Sleeping Pills)       Sulfa         Codeine       Latex       Local Anesthetic		High Blood Pressure	Shortness of Breath							
Pharmacy Name:       Zip Code:       Current Weight:       Ibs.         Check If You Have Any of the Following Allergies:       Barbiturates (Sleeping Pills)       Sulfa         Aspirin       Penicillin       Barbiturates (Sleeping Pills)       Sulfa         Codeine       Latex       Local Anesthetic	List Medications You a	re Currently Takina:								
Pharmacy Name:       Zip Code:       Current Weight:       Ibs.         Check If You Have Any of the Following Allergies:       Barbiturates (Sleeping Pills)       Sulfa         Aspirin       Penicillin       Barbiturates (Sleeping Pills)       Sulfa         Codeine       Latex       Local Anesthetic		, 0								
Check If You Have Any of the Following Allergies:   Aspirin Penicillin   Codeine Latex   Latex Local Anesthetic     Dental History   Reason for Today's Visit:   Date of Last Dental Visit:										
<ul> <li>Aspirin</li> <li>Penicillin</li> <li>Barbiturates (Sleeping Pills)</li> <li>Sulfa</li> <li>Latex</li> <li>Local Anesthetic</li> <li></li> <li>Dental History</li> <li>Reason for Today's Visit:</li> <li></li> <li>Date of Last Dental Visit:</li> <li></li> <li>Date of Last Dental Visit:</li> <li></li> <li>Date of Last Dental X-Rays:</li> <li></li> <li></li> <li></li> <li>Date of Last Dental X-Rays:</li> <li></li> <li< td=""><td>Pharmacy Name:</td><td> Zip</td><td>Code: Curre</td><td>ent Weight:lbs.</td></li<></ul>	Pharmacy Name:	Zip	Code: Curre	ent Weight:lbs.						
Codeine     Latex     Local Anesthetic     Loc	Check If You Have Any	y of the Following Allergi	es:	-						
Dental History         Reason for Today's Visit: Former Dentist:         Date of Last Dental Visit:/       Date of Last Dental X-Rays:/         Date of Last Dental Visit:/       Date of Last Dental X-Rays:/         Check If You have concerns with any of the Following:       Bead Breath       Beod Collection btw Teeth       Periodontal Treatment       Sensitivity to Sweets         Bleeding Gums       Grinding Teeth       Sensitivity to Cold       Sensitivity when Biting	🗆 Aspirin	🗆 Penicillin	Barbiturates (Sleeping Pills)	🗆 Sulfa						
Reason for Today's Visit:	Codeine									
Check If You have concerns with any of the Following:       Image: Sensitivity to Sweets         Bad Breath       Image: Food Collection btw Teeth       Image: Periodontal Treatment       Image: Sensitivity to Sweets         Bleeding Gums       Image: Grinding Teeth       Image: Sensitivity to Cold       Image: Sensitivity when Biting			-							
Check If You have concerns with any of the Following:       Image: Sensitivity to Sweets         Bad Breath       Image: Food Collection btw Teeth       Image: Periodontal Treatment       Image: Sensitivity to Sweets         Bleeding Gums       Image: Grinding Teeth       Image: Sensitivity to Cold       Image: Sensitivity when Biting	-		Former Dent	list:						
□ Bad Breath       □ Food Collection btw Teeth       □ Periodontal Treatment       □ Sensitivity to Sweets         □ Bleeding Gums       □ Grinding Teeth       □ Sensitivity to Cold       □ Sensitivity when Biting				ays: / /						
Bleeding Gums     Grinding Teeth     Sensitivity to Cold     Sensitivity when Biting		•	•							
	<ul> <li>Dieeding Goms</li> <li>Clicking or Popping Jaw</li> </ul>	Ginding reem Loose Teeth/Broken Fillings	□ Sensitivity to Hot	□ Sores/Growths						

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature:

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

#### Assignment & Release

Insurance	Carrier:				
aforement understan	ersigned, certify that I (and/or my dependent) have insurance coverage with the tioned insurance company and assign directly to this office all insurance benefits. I d that I am financially responsible for all charges whether or not paid by insurance. I thorize the use of this signature on all insurance submissions.				
Responsibl	le Party Name:				
Responsibl	le Party Signature:				
Relationshi	ip to Patient: Date: / /				
Initials	If you have questions regarding your insurance coverage, please let us answer them before treatment begins. Otherwise, the assumption will be made that you are aware of your dental coverage.				
Initials	Our team works diligently to verify your insurance information to the best of our capabilities. Please be advised that the co-payment requested for services rendered is only an estimate based on the information provided to us by your insurance company.				
Initials	The information given to our office is never a guarantee of payment. As a courtesy to you, our team will bill your insurance company and attempt the carrier's portion on all services rendered in the office.				
Initials Initials	Payment and/or co-payment is required in full at the time services are rendered. The guarantor of the patient account is responsible for all charges the insurance company does not pay within 60 days of treatment rendered.				
Initials	Past due accounts, those with an overdue balance of more than 60 days, may be charged 1.5% interest per month until the account is reconciled.				
Initials	Delinquent accounts, those with an overdue balance of more than 90 days, will be transferred to either a collection agency or the Indiana State Clerk of Courts. Any and all charges incurred in the pursuit of the debt by any part will be the full responsibility of the account holder.				
	charges incurred in the pursuit of the debt by any part will be the full responsibility of bunt holder.				

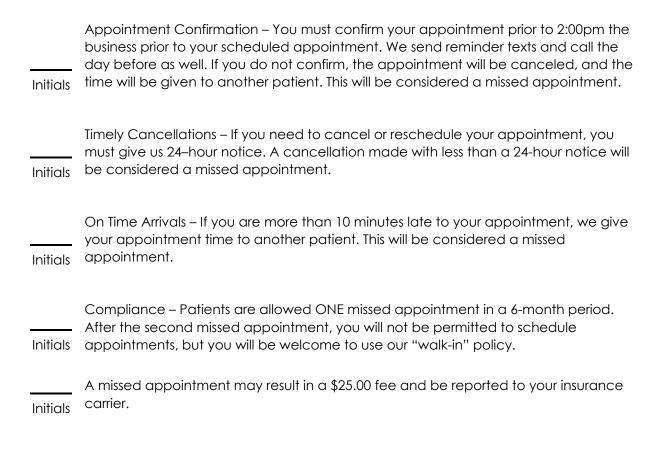
I, the undersigned and thus the guarantor of the account, certify that I have read and agree to abide by the above policies.

Signature: \_\_\_\_\_

#### **Scheduling Agreement**

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or late canceling an appointment means we are unable to fill this appointment time with a fellow patient who may desperately need our care.

Our policy requires:



Many patients require our services. Your help in keeping your appointment enables us to provide better and more timely care to all of our patients.

Signature:\_\_\_\_\_

Date: \_\_\_\_/\_\_\_/\_\_\_\_

## Contact Information for Protected Health Information

l,	, dob: /	/,ı	equest that the
following direction be followed for the discle would include your name, diagnosis(es), test			formation (PHI). PHI
Please list any persons we may disclose your	nformation to:		
	ne Number	F	Relationship
( , ,			
You may leave PHI on my answering m Phone Number ( ) You may leave me text message: Phone Number ( ) You may email me (unencrypted): Email:@			
I have received a copy of this office's Notice	of Privacy Practi	ces.	
Printed Name:			
Relationship to Patient (If Minor):			
Signature:		Dat	e://

# For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented obtaining acknowledgment
- Other (Please Specify):