Kids & Adult DENTAL CENTER Kids & Adult DENTAL CARE Kids & Adult DENTISTRY

Patient Information

First Name: _____ Last Name: _____ Preferred Name: _____
Sex: _____ DOB: ____ /____ /_____ SSN: ____ - ___ - ____ □ Married □ Single □ Minor
Phone: ( )_____ - _____ Email: _____
Preferred Method of Contact: □ Email □ Phone Call □ Text Message
Home Address: _____ City: _____ State: ____ Zip: _____
If minor, provide parent/guardian information:
Parent/Guardian Name: _____ DOB: ____ /____ /_____ SSN: ____ - ___ - ____
How did you hear about us? _____

Medical History

Physician's Name: _____ Phone: ( )_____ - _____
Date of Last Visit ____ /____ /_____
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	□ 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	□ Thyroid Problems
□ Asthma	□ Fainting	□ Mitral Valve Prolapse	□ Tobacco Habit
□ Back Problems	□ Glaucoma	□ Pacemaker	□ Tonsilitis
□ Blood Disease	□ Headaches	□ Pregnancy	□ Tuberculosis
□ Cancer	□ Heart Murmur	□ Radiation Treatment	□ Ulcers
□ 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: _____ Zip Code: _____ Current Weight: _____lbs.
Check If You Have Any of the Following Allergies:

□ Aspirin	□ Penicillin	□ Barbiturates (Sleeping Pills)	□ Sulfa
□ Codeine	□ Latex	□ Local Anesthetic	□ _____

Dental History

Reason for Today's Visit: _____ Former Dentist: _____
Date of Last Dental Visit: ____ /____ /_____ Date of Last Dental X-Rays: ____ /____ /_____
Check If You have concerns with any of the Following:

□ Bad Breath	□ Food Collection btw Teeth	□ Periodontal Treatment	□ Sensitivity to Sweets
□ Bleeding Gums	□ Grinding Teeth	□ Sensitivity to Cold	□ Sensitivity when Biting
□ Clicking or Popping Jaw	□ 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: _____

I, the undersigned, certify that I (and/or my dependent) have insurance coverage with the aforementioned insurance company and assign directly to this office all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

Responsible Party Name: _____

Responsible Party Signature: _____

Relationship 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 Payment and/or co-payment is required in full at the time services are rendered.

_____ Initials 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.

Initials all charges incurred in the pursuit of the debt by any part will be the full responsibility of the account 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: _____ Date: ____ /____ /_____

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:

_____ Initials

Appointment Confirmation – You must confirm your appointment prior to 2:00pm the business prior to your scheduled appointment. We send reminder texts and call the day before as well. If you do not confirm, the appointment will be canceled, and the time will be given to another patient. This will be considered a missed appointment.

_____ Initials

Timely Cancellations – If you need to cancel or reschedule your appointment, you must give us 24–hour notice. A cancellation made with less than a 24-hour notice will be considered a missed appointment.

_____ Initials

On Time Arrivals – If you are more than 10 minutes late to your appointment, we give your appointment time to another patient. This will be considered a missed appointment.

_____ Initials

Compliance – Patients are allowed ONE missed appointment in a 6-month period. After the second missed appointment, you will not be permitted to schedule appointments, but you will be welcome to use our "walk-in" policy.

_____ Initials

A missed appointment may result in a $25.00 fee and be reported to your insurance carrier.

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

I, _____, DOB: ____ /____ /_____, request that the following direction be followed for the disclosure of my Protected Health Information (PHI). PHI would include your name, diagnosis(es), test results, and dates of service.

Please list any persons we may disclose your information to:

Name	Phone Number	Relationship
_____	( )_____ - _____	_____
_____	( )_____ - _____	_____
_____	( )_____ - _____	_____
_____	( )_____ - _____	_____

- You may leave PHI on my answering machine/voicemail:
  - 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 Practices.

Printed Name: _____

Relationship to Patient (If Minor): _____

Signature: _____ Date: ____ /____ /_____

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):

_____

_____

_____

_____