





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										
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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 Cancer Rediation Treatment 	Back Problems	🗆 Glaucoma	Pacemaker	🗆 Tonsilitis						
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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		•	•							
	 Dieeding Goms Clicking or Popping Jaw 	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.				

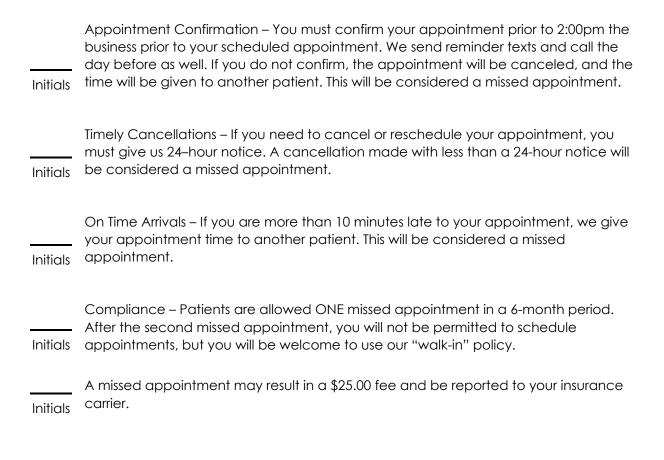
I, the undersigned and thus the guarantor of the account, certify that I have read and agree to abide by the above policies.

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):