Dentistry of Indiana

Welcomes You!

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Please take a moment to answer the necessary questions so that we may be able to better serve you. Thank you.

1. Tell us about yourself

Full Name: _____ Preferred Name: _____ Today's Date: _____
Birth Date: _____ Age: _____ SS#: _____ Home #: _____ Work#: _____
Cell #: _____ Email Address: _____ Driver License #: _____
Address: _____ City: _____State: _____ Zip: _____
Employer: _____ Work Address: _____ Occupation: _____ How long there? ___

How would you prefer to be contacted? Home Phone Work Phone Cell Email Text Message

Other family members seen by us? _____
Other family members needing an appointment? _____

In the event of an emergency, who should we contact? Name: _____ Home #: _____
Cell (Other) #: _____ Relationship to patient? _____

PLEASE LET US KNOW HOW YOU HEARD ABOUT US!

- o Friend / Relative: _____
- o Location
- o Advertising
- o Speedway Town Planner
- o Other: _____

2. Spouse Information

Name: _____
Employer: _____
Work #: _____
Is this person currently a patient in our office? Y / N

3. Person Responsible for Account?

Same as Patient? Y / N Name: _____
Work #: _____Home #: _____
Billing Address: _____
Relationship to Patient: _____
SS #: _____ Employer: _____

4. Primary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone: _____
Group # (Plan, Local, or Policy): _____
Insured's Name: DOB: _____
SS#: Employer: _____
Relationship to Patient: _____

5. Secondary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone: _____
Group # (Plan, Local, or Policy): _____
Insured's Name: DOB: _____
SS#: Employer: _____
Relationship to Patient: _____

6. Medical History

Personal Physician's name and number: _____

Cardiologist's name and number: _____

Orthopedic surgeon's name and number: _____

Your current physical health is: Excellent Good Fair Poor

Are you currently under the care of a physician? Yes No Please explain: _____

Are you taking any prescription / over-the-counter drugs? _____

Are you allergic to any of the following?

Y N Penicillin
Y N Aspirin
Y N Anesthetics
Y N Codeine
Y N Latex
Y N Other: _____

Women:

Y N Are you taking birth control pills?
Y N Are you Pregnant?
Y N Are you nursing?

Please circle any of the following diseases or medical problems you have or have had:

- Allergies
- Anemia
- Arthritis
- Artificial Joints / Bones
- Asthma
- Blood Disease
- Cancer / Chemotherapy
- Diabetes
- Dizziness
- Epilepsy
- Excessive Bleeding
- Fainting
- Glaucoma
- Growths
- Hay Fever
- Heart Disease
- Heart Murmur
- Hepatitis (is yes, type: ___)
- High Blood Pressure
- HIV+ / AIDS
- Jaundice
- Kidney Disease
- Liver Disease
- Mental Disorders
- Nervous Disorders
- Pacemaker
- Radiation Therapy
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Stroke
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease
- Shingles
- Smoking, use of tobacco
  If yes, how much: ___
- Diet Drug Use (Phen-Fen, Redux)
- Congenital Heart Disease
- Artificial Heart Valves
- Hospitalized for any reason
  Please explain: _____
  _____
- Fever Blisters / Cold Sores
- Drug / Alcohol Dependence
- Hemophilia
- Difficulty Breathing
- Blood Transfusion
- Mitral Valve Prolapse

Please explain or list other medical conditions you have had: _____

_____

Have you ever been pre-medicated with antibiotics prior to a dental visit? Yes:_____ / No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

_____ _____

Signature Today's Date

Dentistry of Indiana

Smile Design Center

Patient Name: _____

Previous Dentist: _____ Date: _____

Reason for leaving: _____

What can we do to make your dental experience most comfortable? _____

_____

If I could change my smile, I would …….. (Please check all that apply)

- ○ Whiten
- ○ Straighten
- ○ Close spaces
- ○ Replace silver fillings with tooth colored filling
- ○ Replace old crowns that do not match
- ○ Repair chipped teeth

Have you ever had a serious/difficult problem associated with any previous dental work? Y N

Have you experienced any of the following problems? (Please check all that apply)

- ○ Bleeding gums
- ○ Bad breath
- ○ Soreness in jaw joint
- ○ Grinding of teeth

Do you wear dentures, partials or fixed bridges? Y N If yes, date of placement: _____

Are you currently having discomfort? Y N

Sensitivity to hot, sweets, cold or chewing? Y N

Have you ever received Oral Hygiene Instructions regarding the care of your teeth and gums? Y N

Have you had periodontal cleanings in the past? Y N

Dentistry of Indiana

Financial Policies

Once the Initial examination is completed by your dentist, a Dental Treatment Plan will be created and customized to your needs. All recommendations for treatment will be reviewed and explained with you. Any and all questions will be answered.

This treatment plan will include a breakdown of recommended treatment needs, all applicable fees for each procedure, an estimated amount we would expect your insurance to pay and your co-payment. We do our best in researching your individual policy to provide an accurate copayment, however, it is only an estimate and your insurance has the final say in how much payment they will disburse. We cannot and do not guarantee coverage with any insurance policy due to the many rules and clauses most insurances have in place. Please feel free to ask any questions you may have.

It is very important that you understand your benefits and how these benefits are defined. This arrangement is a contract between the employer, the insured, and the insurance company. Our office is not part of the agreement in benefits. There are instances where the insurance may down code, deny treatment coverage or use their own formula to determine what the payout will be. It is extremely difficult in these rare situations to know exactly what the insurance company will decide to pay.

PAYMENT OR COPAYMENT IS DUE AT TIME OF SERVICE

Full Payment or Full CoPayment is collected at the time the service is provided, unless prior financial arrangements have been made. Please ask about our Cash discount if paid in full at time of service. Payment options are available if necessary.

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

- CASH
- DEBIT CARD
- PERSONAL CHECK
- VISA / MASTERCARD
- CARE CREDIT CARD

I agree to pay for all professional fees at the time of service or my estimated co-payment not covered by dental insurance for myself or the above patient. I realize that I am also responsible for full payment of fees not paid by my insurance company within 30 days from date of service. I also agree to pay interest at the rate of 1.5% monthly on any balance over 30 days from the date of service. In consideration of the services to be provided to the patient, I hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of service or, if no such arrangements are made, in event of default in payment, reasonable collection agency fees equal to thirty (30%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

By providing my cell number, I give prior express consent to receive calls and text messages from the creditor or its third party debt collector at that number, including calls and messages made by using an auto-dialer or prerecorded message.I understand there will be a charge of **$75.00** for canceled, rescheduled, or failed appointments without 48-hour notice. We appreciate your understanding!

_____ _____

Signature of Responsible Party Today's Date

Notice of Privacy Practices Acknowledgment

Dentistry of Indiana
2727 N. High School Rad
Indianapolis, IN 46224

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practice.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you care bound to abide by such restrictions.

I give my permission to Dentistry of Indiana to contact me. Leave a message regarding my appointment.

Patient Name: _____

Relationship to Patient: _____
(i.e. self, mother, father)

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

_____