



# 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: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Relationship to patient? \_\_\_\_\_

### PLEASE LET US KNOW HOW YOU HEARD ABOUT US!

- Friend / Relative Name: \_\_\_\_\_
- Location
- Advertising
- Google and Reviews
- Social Media
- 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: \_\_\_\_\_

Are you required to Pre Medicate with antibiotics prior to dental appts.? Y N

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: \_\_\_\_\_

**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



## *Smile Design Center*

Patient Name: \_\_\_\_\_

Previous Dentist Name: \_\_\_\_\_ Date of last cleaning: \_\_\_\_\_

Are you happy with the appearance of your smile?    Y    N

**We have headphones, blankets, and nitrous oxide available for your comfort needs. Please let us know if you would like any or all and note how we can make your dental experience at Dentistry of Indiana the most comfortable and rewarding! We truly care!** \_\_\_\_\_

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**Are you interested in any of the following.....**    (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
- Facial esthetics: Botox
- Facial esthetics: Dermal Fillers
- Facial esthetics: Lip Augmentation

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

- Bleeding gums
- Bad breath
- Soreness in jaw joint
- Grinding of teeth
- Clenching or grinding
- TMJ discomfort
- Tension headaches
- Orofacial muscle pain in face or neck

Are you currently having tooth 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 (GUM) cleanings / deep cleanings in the past?    Y    N



# 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 downgrade a procedure, 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. I understand that my dental insurance carrier may pay less than expected for services. I agree to be responsible for the full remaining balance of all services rendered on my behalf or my dependents. I agree to pay the full balance if my insurance carrier does not pay within 30 days of treatment rendered.

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Signature of Responsible Party

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Today's Date

## **PAYMENT OR COPAYMENT IS DUE AT TIME OF SERVICE**

Full Payment or Copayment is collected at the time the service is provided. 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
- HSA 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.

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Signature of Responsible Party

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Today's Date



## Dentistry of Indiana Cancellation Policy

The Doctors and Team at Dentistry of Indiana do our best to take care of you and all our patients' dental needs in a caring, friendly, and timely manner. To help accomplish this, we respectfully ask that our time is valued and that all appointments made are confirmed and kept. We will always do our very best to be respectful of your time as well!

We understand that sometimes an emergency may come up or you may become ill. Please read and sign our following cancellation policy to help reach all our patients as best we can.

- ☼ We require 48 hours notice if you are unable to keep an appointment.
- ☼ If you are unable to keep an appointment and cancel within 48 hours or do not show, we will extend to you a courtesy waiver the first time as we understand things can happen.
- ☼ If this should happen a second time, we will ask for a nonrefundable deposit to schedule an appointment in advance. Once you arrive to your appointment, your deposit will either be refunded to your credit card or applied to treatment if needed.
  - It will be \$30 to hold a routine cleaning and exam appointment and \$100 to hold a doctor/treatment (including deep cleaning) appointment.
- ☼ If this occurs more than 3 times, you can take advantage of our VIP list. To accommodate you, let us know the day and times that are best for you and we will call you if an opening becomes available that day and see if it works for your schedule! OR Call on a day you are free and we will see if we have any openings or do our best to see you. We really want to help you achieve Healthy Teeth and Gums!
- ☼ We ask that you confirm your appointment at least 48 hours in advance. Multiple texts are sent and we ask that your appointment is confirmed so that we may plan accordingly. If we do not receive confirmation, your appointment may be given up and offered to patients who need and are waiting for care.

**We appreciate you as a patient and are looking forward to helping you achieve Healthy Teeth and Gums!!!**

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Patient Name Print

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Patient / Guardian Signature

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Date

# Notice of Privacy Practices Acknowledgment

Dentistry of Indiana  
2727 N. High School Rd  
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 are 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: \_\_\_\_\_

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## Office Use Only

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

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_

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