Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available.

Patient Information

Name_____ Nickname _____
DOB _____ Age _____SS# _____
Home Phone_____ Cell Phone _____
Address _____City_____ ZIP _____
Do you prefer appointments in the (circle all that apply): Morning Afternoon No Preference

SEX ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor
E-mail _____Cell phone #2 _____
Employer_____ Employer Phone _____
Employer Address _____City _____Zip _____
Spouse _____Employer_____ Phone # _____
Please name your immediate family (children/last names) _____
Who may we thank for referring you? _____
Person to contact in case of emergency _____Phone #_____

Person Financially Responsible for Account

Name of person
Responsible for this account _____Relation to Patient _____
Address _____City_____ ZIP _____
Driver's License #_____DOB _____SS#_____
Employer_____ Work Phone _____
Currently a patient in our office? ☐ **Yes** ☐ **NO** E-mail_____ Cell _____

Insurance Information

Name of Insured _____Relation to patient _____
DOB _____SS# _____Date Employed _____
Employer _____Work Phone _____
Employer Address _____City_____ ZIP _____
Insurance Co. _____Group #_____ Union/Local #_____
Address _____City_____ ZIP _____

Please indicate if you are covered by any additional insurance **Yes No**
Name of Insured _____Relation to patient _____
DOB _____SS# _____Date Employed _____
Insurance Co. _____Group #_____ Employer _____

Dental History

Reason for today's visit_____
Are you in pain? (If yes, describe)_____
Former Dentist _____Date of Last exam _____
Why are you with a new dentist today? _____
Any concerns you would like to share with us?_____

Medical History

Physician's Name_____ Date of last Visit _____

Have you ever taken any "Fen Phen? **YES** **NO**

Have you had any serious illness or operations? **YES** **NO** If yes describe _____

Have you ever had a blood transfusion? **YES** **NO** If yes, give dates _____

Have you had or have history of Endocardidis? **YES** **NO** If yes, give dates _____

Do you use herbal remedies ? **YES** **NO** If yes describe _____

Do you take a daily (baby) aspirin? **YES** **NO**

(**Women**) Are you pregnant? **YES** **NO** Nursing? **YES** **NO** Taking birth control? **YES** **NO**

Please indicate yes or no if you have or have had any of the following:

Anemia YES NO	Congenital Heart Lesions YES NO	Hepatitis Type_____ YES NO	Scarlet fever YES NO
Arthritis, Rheumatism YES NO	Cortisone treatments YES NO	Hernia Repair YES NO	Shortness of breath YES NO
Artificial heart valves YES NO	Cough, persistent YES NO	High blood pressure YES NO	Skin rash YES NO
Artificial joints, pins etc. YES NO	Cough up blood YES NO	HIV/AIDS YES NO	StrokeDate_____ YES NO
Asthma YES NO	Diabetes YES NO	Jaw Pain YES NO	Swelling of feet YES NO
Back problems YES NO	Epilepsy YES NO	Kidney Disease YES NO	Thyroid Problems YES NO
Bleeding abnormally YES NO	Fainting YES NO	Liver Disease YES NO	Tobacco Habit YES NO
Blood Disease YES NO	Glaucoma YES NO	Mitral Valve Prolapse YES NO	Tonsillitis YES NO
Cancer Type_____ YES NO	Headaches YES NO	Pacemaker YES NO	Tuberculosis YES NO
Chemical Dependency YES NO	Heart Murmur YES NO	Periodontal Disease YES NO	Osteoporosis YES NO
Radiation Treatment YES NO	Ulcer YES NO	Autism YES NO	Mental Disorders YES NO
Learning Disabilities YES NO	Alzheimer's Disease YES NO	Asperger Disease YES NO	Heart Problems YES NO
Chemotherapy YES NO	Respiratory Disease YES NO	Venereal Disease YES NO	Do you Premedicate YES NO
Circulatory Problems YES NO	Hemophilia YES NO	Rheumatic Fever YES NO	Lupus YES NO
Fibromyalgia YES NO	Use of recreational drugs or alcohol YES NO		

List Medications you are currently taking and the correlation Diagnosis:

_____

_____

Allergies: (Circle) medications

Latex Sulfa Codeine Iodine

Local Anesthetic Penicillin **Other**_____

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 of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Date

For office use only Date reviewed_____ Dr Signature_____

Continue

Authorization and Release (Required)

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.
I certify that I, and/or my dependent(s), Have insurance coverage with _____
Name of Insurance
and assign directly to *Indian Hills Dental* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above named dentist may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Date

Payment Options (Required)

To keep cost of Dentistry down, and to continue to provide quality care to our valued patients, we now only accept payment in full the day of treatment. We do accept insurance payments, we do process insurance claims as a courtesy to all our insurance patients, Please note insurance is never a guarantee of payment, we attempt to get all estimated portions and inform you prior to all dental treatment, we ask that you indicate form of payment desired for your dental portion.

We pride ourselves in always informing you of any cost you may incur before we begin treatment and to always receive your consent for all services rendered. There is a $25.00 charge for any returned checks. If a check is returned and not paid within 7 days of date, legal action may be taken for collection. You will assume any costs associated with collection of returned checks. **Initials _____**

Please (✓) the option(s) most convenient for you to settle your account, in full today.

- ☐ **Cash/ Check** (*in full day of treatment*)
- ☐ **Visa /MasterCard** (*in full day of treatment*)
- ☐ **Financing** *through* **Care Credit** *(on approved credit, see front office for application)*
  Interest free and low monthly payments available.

Privacy Practices

- ☐ **I hereby acknowledge I have been provide an opportunity to review a copy of this practices NOTICE OF PRIVACY PRACTICES.(HIPAA) I further understand that the practice will offer me updates to this NOPP should it be amended, modified or changes in any way. Initials _____**
- ☐ **I hereby acknowledge I have been provide an opportunity to review a copy of this practices Material Safety Data Sheet (MSDS) Acknowledgement. Initials _____**
- ☐ **I give Indian Hills Dental Consent to use my photos in official office use. Initials _____**
- ☐ **You have the right to request a copy of your records/ x-rays, but there will be a $25.00 fee to duplicate x-rays taken by us. We require by law to retain originals on file. Initials _____**

Appointment Guideline

We request that all our patients give us a 24hr notice to cancel or reschedule their dental appointment. This will allow sufficient time to inform other patients of the availability in our Dr.'s schedule.
Thank you for your cooperation.
We understand emergencies please inform us as soon as you know you will need to change your scheduled appointment.

If you do not cancel and or fail to show as scheduled, you will be charged a broken appointment fee starting at $25.00 per appointment. Arriving 15 min after your appointment is considered a no show.

_____ _____
Signature *Date*

Update Medical History

Since your last visit

Have you seen a medical Doctor? **Yes No**

Have you had a change in your medications? **Yes No If yes describe** ____________________

Have you had a change in your medical condition or had surgery? **Yes No**

If yes describe ____________________

If no changes, please write circle NONE

____________________________________ __________________

Signature *Date*

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If no changes, please write circle NONE

____________________________________ __________________

Signature *Date*

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If yes describe ____________________

If no changes, please write circle NONE

____________________________________ __________________

Signature *Date*

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If no changes, please write circle NONE

____________________________________ __________________

Signature *Date*

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____________________________________ __________________