

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? _____

Cosmetic Dental History

1. Do you love the way your smile looks? Yes No
2. Do you feel comfortable showing your teeth when you laugh or smile? Yes No
3. In you could change anything about your smile it would be **(circle all that apply)**:

Color of your teeth *Too much or too little of teeth show when I smile* *Gaps between teeth*
Size/ Shape of teeth *Too much or too little of gum shows when I smile* *Alignment of teeth*
Other _____

4. Do you have **(circle all that apply)**:

Sensitive or receding gums *Worn /broken/chipped teeth* *Old or discolored fillings*
Missing teeth *Old crowns that have dark edges at the top*
Other _____

5. In your line of work or lifestyle, do you **(circle all that apply)** :

Visit businesses or clients *Travel* *Speak publicly* *Other* _____

6. If you had a smile makeover do you think you'd feel **(circle all that apply)** :

More confident *More optimistic* *Healthier* *Just Ok*
No Different *Other* _____

7. Do you or someone in your family have issues with any of the following **(circle all that apply)** :

Chronic bad breath *Grinding of teeth* *Snoring* *Other* _____

Medical History

Physician's Name _____ Date of last Visit _____

Have you ever taken any "Fen Phen? **YES NO** Do you take a daily aspirin? **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 _____

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

Please **(circle)** if you have or have had any of the following:

Anemia	Congenital Heart Lesions	Hepatitis Type _____	Scarlet fever
Arthritis, Rheumatism	Cortisone treatments	Hernia Repair	Shortness of breath
Artificial heart valves	Cough, persistent	High blood pressure	Skin rash
Artificial joints, pins etc.	Cough up blood	HIV/AIDS	Stroke Date _____
Asthma	Diabetes	Jaw Pain	Swelling of feet or ankles
Back problems	Epilepsy	Kidney Disease	thyroid Problems
Bleeding abnormally	Fainting	Liver Disease	tobacco Habit
Blood Disease	Glaucoma	Mitral Valve Prolapse	Tonsillitis
Cancer Type _____	Headaches	Pacemaker	Tuberculosis
Chemical Dependency	Heart Murmur	Periodontal Disease	Osteoporosis
Radiation Treatment	Ulcer	Autism	Mental Disorders
Learning Disabilities	Alzheimer's Disease	Asperger Disease	Do you Pre Medicate Y/N
Chemotherapy	Heart Problems	Respiratory Disease	Venereal Disease
Circulatory Problems	Hemophilia	Rheumatic Fever	Alcohol or drug abuse

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. **Initials** _____

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

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Date

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If no changes, please write circle NONE

Signature

Date