Patient's Legal Name _____ ***Date*** _____

Name You Prefer To Be Called _____

Male / Female Marital Status S M D W

Address _____

City _____ State _____ Zip _____

Home # _____ Business # _____ Cell # _____

E-mail: _____

Social Security # _____

Patient's Age _____ Birthdate _____

Patient Employed By _____

Business Address _____

Present Position _____ How Long Held _____

Spouse's Name _____

Spouse Employed By _____ Work # _____

Business Address _____

Spouse's Social Security # _____

Spouse's Date of Birth _____

Whom may we thank for referring you? _____

Insurance Information

Dental Insurance Company _____

Address: _____

Phone # and Policy Number: _____

Name of insured, D.O.B., Identification # _____

_____

Secondary Insurance: Name and Address _____

_____

Phone # and Policy Number: _____

Nearest Relative (not living with you):

Name _____ Phone # _____

Please list everyone living with you:

Name Ages Sex

_____

_____

_____

_____

AGREEMENT: As a courtesy we offer assistance with filing your insurance at no additional charge to you, although any follow-up with your insurance carrier remains your responsibility. Your insurance policy is an agreement between you and your insurance carrier. If your insurance company does not pay your claim within 60 days the entire balance will be billed to you. All deductibles and estimated co-payments are due at the time of service. Any returned checks will be charged $100.00 to cover our bank charges and administrative fees. An appointment in our practice is a confirmation. You understand that we will add a $100.00 missed appointment fee to your account when a reserved time is broken or cancelled without giving 48 hours notice. _____ *Initial*

I am the responsibie party for this account. I understand that I will be held responsible for the cost of collecting on my unpaid account, including, but not limited to, court costs, attorney fees and collection fees for myself or the above patient. I authorize the release of all medical or dental information neccessary to process my claims and I authorize the release of this same information, when neccessary, to other providers rendering medical/dental care. I assign all insurance benefits to Dr. Herd or Washington Square Cosmetic and Family Dentistry. This assignment will remain in effect until revoked by me in *writing*. A photocopy of this assignment is to be considered as valid as the original.

Signature _____ Printed Name _____

PATIENT NAME _____ DATE _____

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last Visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist _____
Date of last full mouth x-rays (16 small films or panoramic): _____

MEDICAL HISTORY

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Yes No
_____
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other _____
Women (Please check): ❑ Pregnant/trying to get pregnant ❑ Nursing ❑ Taking oral contraceptives _____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment...premedication may be required.

	Yes	No
Heart Disease/Surgery*	❑	❑
Heart Murmur*	❑	❑
Irregular Heart Beat	❑	❑
Angina/Chest Pain	❑	❑
Heart Attack/Failure	❑	❑
Congenital Heart Disorder	❑	❑
Mitral Valve Prolapse*	❑	❑
Scarlet Fever	❑	❑
Artificial Heart Valve*	❑	❑
Heart Pace Maker*	❑	❑
Pulmonary Shunt	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Bacterial Endocarditis	❑	❑
Unexplained Fever	❑	❑
Bruise Easily/Blood Disease	❑	❑
Anemia	❑	❑
Excessive Bleeding	❑	❑
Sickle Cell Disease	❑	❑
Hemophilia(Bleeding Problem)	❑	❑

	Yes	No
Leukemia	❑	❑
Recent Blood Transfusion	❑	❑
Swelling of Limbs	❑	❑
Lung Disease	❑	❑
Breathing Problem	❑	❑
Shortness of Breath	❑	❑
Frequent Cough	❑	❑
Hay Fever	❑	❑
Sinus Trouble	❑	❑
Asthma	❑	❑
Bloody Sputum	❑	❑
Emphysema	❑	❑
Tuberculosis	❑	❑
Cancer	❑	❑
X-Ray Treatments(Radiation)	❑	❑
Chemotherapy	❑	❑
Stomach/Intestinal Disease	❑	❑
Ulcers	❑	❑
Recent Weight Loss	❑	❑
Frequent Diarrhea	❑	❑

	Yes	No
Diabetes	❑	❑
Excessive Thirst	❑	❑
Hypoglycemia	❑	❑
Liver Disease	❑	❑
Hepatitis A (Infectious)	❑	❑
Hepatitis B or C	❑	❑
Night Sweats	❑	❑
Yellow Jaundice	❑	❑
Kidney Problems	❑	❑
Renal Dialysis	❑	❑
Thyroid Disease	❑	❑
Parathyroid Disease	❑	❑
Arthritis/Gout	❑	❑
Rheumatism	❑	❑
Pain in Jaw Joints	❑	❑
Cortisone Medicine	❑	❑
Artificial Joint*	❑	❑
Venereal Disease	❑	❑
AIDS	❑	❑
HIV Positive	❑	❑

	Yes	No
Genital Herpes	❑	❑
Drug Addiction/Alcoholism	❑	❑
Tattoos/Body Piercing	❑	❑
Cold Sores	❑	❑
Fever Blisters	❑	❑
Herpes	❑	❑
Stroke	❑	❑
Convulsions	❑	❑
Epilepsy or Seizures	❑	❑
Fainting or Dizziness	❑	❑
Glaucoma	❑	❑
Tumors or Growths	❑	❑
Nervousness	❑	❑
Psychiatric Care	❑	❑
Alzheimer's Disease	❑	❑
Allergies (Medicines)	❑	❑
Allergies (Pollen/Dust)	❑	❑
Hives or Rash	❑	❑
Need Premedication?	❑	❑
Ever taken fen-phen?*	❑	❑

Have you ever had any other serious illness not checked above? Describe _____ Yes No

In the event of an emergency, who should we contact?

Name _____ Phone # _____
Name _____ Phone # _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ E-mail:_____

I have received a copy of this office's Notice of Privacy Practices.

Signature:_____Date:_____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health informations, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Richard M. Herd, Jr.

Telephone: (317) 897-4163 Fax:_____

E-mail:_____

Address: 830 N. Mitthoeffer Rd., Indianapolis, IN 46229

Right to Revoke: You will the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.