Patient Information:

Name: ______________________ Date: ______________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Spouse's Name: ______________

SS#: ______________ Birth Date ______________

Home Phone: ______________

Address: ______________________

Cell Phone: ______________

____

Email: ______________

Contact Person (who does not live with you) Name: ______________ Phone Number: ______________

Responsible Party: if child or another adult

Name of Person Responsible for Account: ______________ Relationship to Patient: ______________

SS#: ______________ Birth Date ______________

Home Phone: ______________

Address: ______________________

Cell Phone: ______________

____

Email: ______________

Insurance Information: please provide us with your dental insurance card so we may make a copy

Name of Primary Insured: ______________ Relationship to Patient: ______________

SS#: ______________ Insured Birth Date ______________

Home Phone: ______________

Employer: ______________________

Work Phone: ______________

Employer Address: ______________________

Insurance Company: ______________Group # ______________

Policy #: ______________

Insurance Company's Phone Number: ______________

Do you have secondary Insurance? ______

Have you used your Insurance this year or paid your deductible? ______

Referral Information:

How did you hear about us? ☐ Internet ☐ Mail ☐ Yellow Pages ☐ Drive By ☐ Insurance Company ☐ Referral

Who referred you to our dental practice? ☐ Patient ☐ Doctor/Dentist ☐ Spouse ☐ Friend ☐ Family Member

Name of person or office referring you to our practice: ______________________

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected Health Information. Please see our HIPPA Notice of Privacy Practices. Thank you for choosing our practice to serve your dental needs now and in the future.

Please complete and sign the other side of this form >>

Patient Medical History:

Name of Physician: ______________________ Last Exam: ____________ Office Phone: ____________

	Yes	No
1. Are you under Medical Treatment now?	☐	☐
2. Are you taking any Medications?	☐	☐

If yes, what medication(s) are you taking? ________

____

____

	Yes	No
4. Do you smoke or use tobacco products?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Have you been Hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐

If yes, please explain ______________________

3. Do you have or have you had any of the following?

- ☐ **Allergies:**
  - ☐ Latex ☐ Penicillin
  - ☐ Sulfa ☐ Codeine
  - ☐ Iodine ☐ Metals
  - ☐ Other ____________
- ☐ Aids/HIV
- ☐ Anemia/Hemophilia
- ☐ Arthritis
- ☐ **Artificial Joints/Parts**
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer/Tumor
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ **Excessive Bleeding**
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ **Heart Disease**
- ☐ **Heart Murmur**
- ☐ Heart Attack
- ☐ **Hepatitis**
- ☐ High Blood Pressure
- ☐ Joint Replacements
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Nervous Disorders
- ☐ **Nursing**
- ☐ **Mitral Valve Prolapse**
- ☐ Pacemaker
- ☐ **Pregnancy**
  - ☐ Due Date ________
- ☐ **Pre-Medication**
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ **Rheumatic Fever**
- ☐ Sinus Problems
- ☐ Skin Rash/Hives
- ☐ Spina Bifida
- ☐ Stomach Problems
- ☐ Stroke
- ☐ TMJ and/or Jaw Pain
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other________________

Patient Dental History:

Name of Previous Dentist ______________________________ Date of Last Exam or Cleaning ____________

1. Have you ever had any complications during/following dental treatment? ☐ Yes ☐ No
2. Are your teeth sensitive to hot, cold or sweet liquids/foods? ☐ Yes ☐ No
3. Do you have pain in your teeth or a certain tooth? ☐ Yes ☐ No
4. Have you ever had clicking or pain in your jaws or difficulty opening or closing? ☐ Yes ☐ No
5. Do you have frequent headaches? ☐ Yes ☐ No
6. Do you clench or grind your teeth? ☐ Yes ☐ No
7. Have you ever had a difficult extraction(s) or prolonged bleeding following an extraction in the past? ☐ Yes ☐ No
8. Have you had any orthodontic treatment (braces)? ☐ Yes ☐ No
9. Do you like your smile? ☐ Yes ☐ No
10. If you could change one thing about your smile or teeth, what would it be? ______________________

Authorization and Release:

I certify that I have read, answered and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I also authorize the dentist(s) and/or dental office to release any information to third party payors and/or other healthcare practitioners.

X______________________________

Practice Information and Policies

I have received and reviewed a copy of your dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask the dental practice's Privacy Official if I have any questions about these policies and procedures.

Print name:____

Signature:____

Date:______________________

List the names of anyone whom we *may/may not* share your information with:

____

Please *check* if you **DO NOT** want to be contacted regarding appointments, test results, insurance matters, account balances by any of the following:

___home phone____cell phone___work phone___mail___email___text message

210 East Water Street ▪ Pendleton, IN 46064
P: 765-778-7558 ▪ F: 765-778-9000
E: familydentalofpendleton@comcast.net
www.familydentalpendleton.com

Financial Policies

Family Dental of Pendleton accepts: **Cash, personal check, Credit Cards**, Care Credit

Care Credit: We have a financing company that provides our patients with an interest free loan for dental treatment (we pay the interest for you) for those who qualify upon credit approval.

Dental Insurance: Please note that your dental insurance policy is a contract between you and your insurance company. Our goal is to assist you in maximizing your benefits. Each company pays an insurance premium for specific coverage which fits the employer's budget. Each plan is different in its covered services. It is the sole responsibility of the patient to insure that our practice accepts or is in network with your insurance. We encourage you to become familiar with your policy exclusions, deductibles, annual maximum and required co-payments. We strive to estimate your out of pocket copay, but please understand that we are simply a third party interpreting your insurance plan as a courtesy.

Our expectations of you as the owner of the policy:

1) Payment of fees not covered by your insurance plan are due at the time of service. We will let you know of these estimated fees before any treatment has started.
2) Please understand that the insurance policy belongs to **you** and we have no leverage to obtain payment from your insurance carrier.
3) Realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called UCR) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, *not* our fees or recommended treatment.
4) You will have to take responsibility for any fees your insurance has not covered after 30 days.

I hereby authorize Family Dental of Pendleton and any associates to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Family Dental of Pendleton. I understand I am responsible for any unpaid balances by insurance at 90 days. I understand I am responsible for all charges associated with this account. Co-pays that are refused at time of service will have $5.00 billing fee. If collection procedures are required, patient will be responsible for all collection fees.

Appointment Guidelines

- Please call to let us know if you will be late, and give us an estimated arrival time. At this time, we may need to reschedule your appointment.

- We require 48 BUSINESS HOURS notification for any rescheduling or cancellation of appointments. Failure to give adequate notice or missing a dental appointment will result in a $50 failed appointment fee. There may be additional charges if a dental procedure is missed or rescheduled with less than a 48 hour notice.

- We will make a courtesy call 2-3 days prior to your appointment. If we have not heard back from you within 48 hours prior to your appointment, we reserve the right to offer your appointment time to another patient.

____ _____________
(Print Responsible Party or Patient Name) (Date)

____ _____________
(Signature Responsible Party or Patient Name) (Date)