TIME 09:56 AM

DATE 10/5/2023

PATIENT REGISTRATION

ID: AUTO Chart ID:

First Name: . Last Name: . Middle Initial:

Patient Is: ☐ Policy Holder ☑ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: Indianapolis State / Zip: IN 46219-6627 Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☑ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist: Sarah LeClere

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg: Jamie Westphal

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: $0.00 Rem. Deduct: $0.00

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: $0.00 Rem. Deduct: $0.00

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No		
Do you use tobacco?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

EAST INDY
DENTAL CARE

General Consent

Patient's Name_____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at East Indy Dental Care. These procedures include but are not limited to: examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, resin restorations, removal of amalgam restorations, crowns, periodontal gum treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

Printed Name:_____

Signature:_____ Date:_____

This section needs to be completed for children under the age of 18 by a parent of legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above-named minor child. If I an unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

If Child is over 13, please check one:

- ☐ Since my child is over the age of 13, I also give permission for them to be present for treatment unaccompanied by an adult. I understand that no invasive treatment, such as extractions or the initiation of root canal therapies will be performed unless I am notified by telephone. In the event of an emergency, when I cannot be reached, I give permission to perform whatever therapies are deemed necessary by the treating provider.
- ☐ Although my child is over 13, I wish to be present for all treatments performed.

Signature of Parent/Legal Guardian_____ Date_____

This consent shall be considered in effect until rescinded or revoked.

Acknowledgement of Receipt of HIPAA Notice & Privacy Practices

- I, _____, hereby acknowledge that I have received and reviewed a copy of East Indy Dental Care's HIPAA Notice of Privacy Practices.
- I understand that East Indy Dental Care's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of East Indy Dental Care's revised HIPAA Notice of Privacy Practices upon request.
- I understand that if I have questions about East Indy Dental Care's HIPAA Notice of Privacy Practices, I may contact the privacy official at East Indy Dental Care.
- I understand that it is my right to reuse this acknowledgement should I so choose, and that East Indy Dental Care will not refuse treatment to me if I do.
- I further understand that I may contact the Security of the U.S. Department of Health and Human Services should I have concerns regarding East Indy Dental Care's privacy policies and procedures.

Patient Name: _____

Printed Name:_____(Relationship if Minor)_____

Signature: _____ Date: __/__/____

HIPAA Information Communication Release

The HIPAA privacy law dictates that we are only authorized to communicate with patients themselves, guardians, insurance providers and patients' physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking "DO NOT RELEASE INFORMATION" box below.

I give the following named person(s) authorization to take messages or speak with the office of East Indy Dental Care on my behalf, regarding (please check all items authorized). Please note that information will be shared with these parties on a strictly "as needed" basis.

NAME OF AUTHORIZED PERSON(S): _____
Relationship: _____ Phone Number: _____
Able to Discuss (circle all that apply):

Appointments: Y | N Financial: Y | N Dental Treatment: Y | N Insurance: Y | N Medical History: Y | N
Other: _____

NAME OF AUTHORIZED PERSON(S): _____
Relationship: _____ Phone Number: _____
Able to Discuss (circle all that apply):

Appointments: Y | N Financial: Y | N Dental Treatment: Y | N Insurance: Y | N Medical History: Y | N
Other: _____

DO NOT RELEASE INFORMATION TO ANYONE: _____ (Initial)

I understand that my express written consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contact listed above.

Patient's Name: _____ Date: _____

Signature of Patient or Authorized Representative:

_____

EAST INDY
DENTAL CARE

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing our practice for your dental needs. It is our goal to provide you with the highest quality healthcare services possible. We ask that you please read and understand your financial responsibilities prior to receiving services.

1. I understand that I am responsible for knowing the policy provisions and rules of my insurance coverage.

2. I understand that any fee estimate or insurance estimate given to me as part of my treatment plan is only an **estimate.** Due to the nature of dental care and unforeseen complications or changes that may arise during procedures, fees and/or treatment may also change as a result.

3. I understand that **I am financially responsible for any amount not covered by my insurance** including, but not limited to, co-pays, co-insurances, deductibles and non-covered services.

4. I understand that if I do not have valid/accepted dental insurance, I am financially responsible for all fees for provision of dental services and that, unless other arrangements have been made in advance, payment of these fees is **expected in full at the time services are rendered.** (Accepted modes of payment: cash, personal check, credit card, debit card, or CareCredit.)

5. If I choose "Assignment of Benefits" with regards to my dental plan reimbursements, I authorize dental benefits, otherwise payable to me, to be directly paid to East Indy Dental Care. I also grant my permission for EIDC staff to telephone me at home/work to discuss matters related to this form.

5. I understand that failure to remit payment for any amounts deemed "patient responsibility" may result in my account being referred for collection activity and that I will be financially responsible for any additional fees incurred as a result. I understand that my future treatments may be delayed until the balance has been paid.

6. I understand that any appointments missed, or not canceled/rescheduled with (24) hours notice, will result in my being charged a Missed Appointment Fee of $35 per missed office visit.

7. I understand that I will be charged $35 for any check returned by my bank for any reason.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO THESE TERMS.

Patient Name: _____

Printed Name: _____ (Relationship if Minor) _____

Signature: _____

Missed Appointment Cancellation/No Show Policy

Thank you for trusting your care to our team at East Indy Dental Care. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact out office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. As Cancellations and No Shows have become more common to our practice in recent years, please see our Appointment Cancellation/No Show policy below:

- Effective 1/1/2023: Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$35.00 fee.**
- Any patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will again be charged a **$35.00 fee.**
- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur, the patient may be dismissed with written notice from East Indy Dental Care.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**
- Please **expect a confirmation text or call** 24 hours in advance to keep your appointment reserved. If we do not receive a positive confirmation, your appointment may be given to someone in need.
- We do our best to keep patient information current. If we send confirmations to an invalid number, the policy remains in effect.

We understand that there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience an extenuating circumstance, the office staff may receive authority from Dr. LeClere to waive the No Show fee. You may contact East Indy Dental Care by text 24 hours a day, 7 days a week at 317-759-4873. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a text message for the staff. You may also email: eastindydental@gmail.com.

Thank you for your understanding and cooperation!

Patient Name:_____

Printed Name:_____(Relationship if Minor)_____

Signature:_____ Date: _____