New Patient Paperwork

PATIENT INFORMATION **DATE:** ______________________

Full Name: ______________________ Cell Ph: ______________ Alt. Ph: ______________

Address: ______________________ City/State: ______________ Zip: ______________

Email: ______________________ Referred By: ______________________

SSN: ______________ DOB: ______________ Sex: ______________ Marital Status: ______________

Employer: ______________________ Occupation: ______________ Work Ph: ______________

Parent/Guardian: ______________________ Relationship: ______________ DOB: ______________

Emergency Contact: ______________________ Relationship: ______________ Cell Ph: ______________

INSURANCE INFORMATION

Insurance Carrier Name: ______________________ Insurance Carrier Ph: ______________________

Subscriber Employer Name: ______________________ Subscriber Employer Ph: ______________________

Subscriber Name: ______________________ Subscriber Relationship to Patient: ______________________

Subscriber ID # or SSN: ______________________ Group #: ______________ Subscriber DOB: ______________

DENTAL CONDITIONS

Bleeding Gums Y | N Any Pain / Discomfort Y | N Date of Last Dental Exam: ______________________

Hot/Cold Sensitivity Y | N Earaches / Neck Pain Y | N Date of Last Dental X-Rays: ______________________

Teeth Catch Food Y | N Jaw / Biting Issues Y | N Reason for Visit: ______________________

Dry Mouth Y | N Grind Teeth at Night Y | N Happy with Your Smile? Y | N

Prev Perio Treatment Y | N Oral Sores / Ulcers Y | N If Not, Please Explain: ______________________

Prev Ortho Treatment Y | N Dentures / Partials Y | N ______________________

MEDICAL CONDITIONS

General Health Problems Y | N If So, Please Explain: ______________________

Ever Had Surgery Y | N If So, Please Explain: ______________________

Use Tobacco Y | N If So, Please Explain: ______________________

Taking Any Medications Y | N If So, Please Explain: ______________________

Currently Seeing a Doctor Y | N If So, Please Explain: ______________________

Physician Name: ______________________ Physician Ph: ______________________

Heart Problems Y | N If So, Please Explain: ______________________

Healing Problems Y | N If So, Please Explain: ______________________

New Patient Paperwork

MEDICAL CONDITIONS (CONT)

Currently Pregnant Y | N If So, Please Explain: ______________________

Taking Blood Thinners Y | N If So, Please Explain: ______________________

Joint Replacement Y | N If So, Please Explain: ______________________

Need Premedication Y | N If So, Please Explain: ______________________

Currently Taking Any of the Following: Fosamax | Boniva | Actonel | Other Bisphosphonates *(Please circle all that apply)*

Heart Murmur	Y | N	Blood Transfusion	Y | N	Diabetes	Y | N	Neurological Disorders	Y | N
Mitral Valve Prolapse	Y | N	If So, Date: ______		If So, Type: ______		If So, Type: ______	
Artificial Heart Valves	Y | N	Anemia	Y | N	Chronic Pain	Y | N	Mental Health Disorders	Y | N
Rheumatic Fever	Y | N	Hemophilia	Y | N	Eating Disorder	Y | N	If So, Type: ______	
Cardiovascular Disease	Y | N	AIDS / HIV	Y | N	Malnutrition	Y | N	Recurrent Infections	Y | N
Angina	Y | N	Arthritis	Y | N	Gastrointestinal Disease	Y | N	If So, Type: ______	
Arteriosclerosis	Y | N	Autoimmune Disease	Y | N	Reflux / Heartburn	Y | N	Kidney Problems	Y | N
Congestive Heart Failure	Y | N	Rheumatoid Arthritis	Y | N	Ulcers	Y | N	Night Sweats	Y | N
Coronary Artery Disease	Y | N	Lupus	Y | N	Thyroid Problems	Y | N	Osteoporosis	Y | N
Damaged Heart Valves	Y | N	Asthma	Y | N	Stroke	Y | N	Swollen Glands	Y | N
Heart Attack	Y | N	Bronchitis	Y | N	Glaucoma	Y | N	Severe Headaches	Y | N
Low Blood Pressure	Y | N	Emphysema	Y | N	Hepatitis	Y | N	Migraines	Y | N
High Blood Pressure	Y | N	Sinus Trouble	Y | N	If So, Type: ______		Rapid Weight Loss	Y | N
Congenital Heart Defects	Y | N	Tuberculosis	Y | N	Jaundice / Liver Disease	Y | N	STD	Y | N
Pacemaker	Y | N	Cancer	Y | N	Epilepsy	Y | N	Excessive Urination	Y | N
Rheumatic Heart Disease	Y | N	Radiation Treatment	Y | N	Fainting / Seizures	Y | N	______	
Abnormal Bleeding	Y | N	Chest Pain	Y | N	Sleep Disorders	Y | N	______	

Any Condition Not Mentioned Above: ______________________

ALLERGIES

Latex / Rubber?	Y | N	Sulfa Drugs?	Y | N	Aspirin?	Y | N	Hay Fever / Seasonal?	Y | N
Local Anesthetics?	Y | N	Codeine / Narcotics?	Y | N	Metals?	Y | N	Animals?	Y | N
Penicillin / Antibiotics?	Y | N	Barbiturates / Sedatives?	Y | N	Iodine?	Y | N	Food?	Y | N

Any Allergy Not Mentioned Above: ______________________

Office Policy Information

CONSENT FOR SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: By signing below, I acknowledge that I have received and reviewed a copy of this office's Notice of Privacy Practices according to federal and state requirements and I consent to the use of my records and information to carry out treatment, payment activities, and health care operations as set forth in this office's Privacy Notice.

I hereby authorize the office or designated staff to take x-rays, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the office to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary.

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to the office. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan.

APPOINTMENT CANCELLATION POLICY

At our office, we have implemented an appointment reminder and confirmation system that utilizes emails and cell phone text messages, as well as personal phone calls, to remind you and your family members of upcoming appointments with our office. It is our pleasure to provide these services to our patients at NO CHARGE as a means to better enhance your patient experience.

If you are ever unable to keep a scheduled appointment with our dental office, we require at least a two (2) business day notice by calling our office to reschedule or cancel your appointment. If your notice is not received within the two (2) business day window, a small, short-notice fee of $25.00 may be charged to your account.

PATIENT FINANCIAL RESPONSIBILITY

As a condition of your treatment by this office, I understand that payment in full is due at the time services are rendered. I may pay with cash, personal check, credit or debit card, or CareCredit. I understand that all emergency dental services or any service performed after regular business hours must be paid at the time services are rendered.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all delinquent accounts, starting on the date the debt was incurred.

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

In the event that my account becomes delinquent, I understand that future treatment may be delayed until the balance has been paid. I also understand that if my account becomes delinquent, I shall be solely responsible for any and all collection fees, attorney fees, court costs, interest charges, and any other reasonable fee or charge as a result of my delinquent account.

If I choose Assignment of Benefits with regards to my insurance plan reimbursements, I authorize payment of dental benefits, otherwise payable to me, directly paid to East Indy Dental Care. I also grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

By signing below, I certify that I have read, fully understand, and agree to the above terms and office policies.

Patient / Guardian Signature: ______________________________ Date: ______________