Design in Dentistry

PATIENT INFORMATION

This appointment is for □ Yourself □ Your Child

Patient Full Name _____**Social Security #** _____

Birth Date _____ Age _____ □ Male □ Female _____

Address _____ City _____State ____ Zip _____

Full Time Student _____ □ Yes □ No School Name_____

Employer _____ Occupation _____

Previous Dentist _____ Previous Dentist Phone_____

Current Physician _____ Current Physician Phone_____

TELEPHONE & EMAIL

Home Phone _____ Work Phone_____ Cell Phone_____

Email _____ _____

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

Name_____ Relationship _____

Home Phone _____ Work Phone _____

RESPONSIBLE PARTY

Who is responsible for this patient

Full Name _____**Social Security #** _____

Are you □ Single □ Married □ Divorced □ Widowed

Birth Date _____ Age _____ □ Male □ Female _____

Address _____ City _____State ____ Zip _____

Employer _____ Occupation _____

Home Phone _____ Work Phone_____

INSURANCE INFORMATION

Dental Coverage □ Yes □ No

Insured's Name _____ **Relation** _____

Insured's Social Security # _____ **Birth Date** _____

Insured's Employer _____

Insurance Group # _____ **Insurance Policy #** _____

Insurance Co. Name _____ **Insurance Co Phone** _____

SECONDARY INSURANCE

Insured's Name_____Relation_____

Insured's Social Security # _____ Birth Date_____

Insured's Employer _____

Insurance Group # _____ Insurance Policy # _____

Insurance Co. Name _____ Insurance Co Phone _____

MEDICAL HISTORY

FOR
1150--A A
Birth Date:

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, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

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 _____ DATE _____

DENTAL HISTORY

We appreciate the confidence you have placed with us to provide Dental Care to you. All information on this chart is necessary for our records and is strictly confidential.

Patient Name: First_____MI_____Last_____DOB_____

Family History: Spouse's Name_____Children?____ If yes, How Many?_____

And their names_____

Please Let Us Know How You Heard About Us.
___Friend/ Relative_____ ___Location ___Advertising (Flyer, event, etc)
___Insurance Company ___Yellow Pages ___Web Site
___Other_____

DENTAL HEALTH INFORMATION

Thank you for providing us with important information that will help us serve you better.

	YES	NO
Are you having any discomfort?	___	____
Any sensitivity to hot, cold, sweets, chewing?	___	____
Does Dental Treatment make you nervous?	___	____
Have you experienced any of the following problems:		
Bleeding Gums	____	____
Bad Breath	____	____
Soreness of Jaw Joint	____	____
Grinding of Teeth	____	____
Snoring	____	____
Do you think your dental health effects your overall health?	____	____
Do you think it is important to have your teeth cleaned every six months?	____	____
Do you prefer to save your teeth?	____	____
Do you take fluoride supplement?	____	____

	YES	NO
Is the brightness of your teeth important?	____	____
Do you smoke or use tobacco in any form?	____	____
Do you drink coffee or tea?	____	____
If I could change my smile I would make my teeth:		
Whiter	____	____
Straighter	____	____
Close Gap	____	____
Replace mercury fillings with tooth colored fillings	____	____
Repair chipped teeth	____	____
Replace missing teeth	____	____
Less Gum Showing	____	____
Replace crowns/caps that don't match	___	____
Have you ever had a special coating applied to your back teeth to protect from tooth decay?	____	____

On a scale of 1-10 with 10 being the highest rating: (Please circle one)

How important is your dental health?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
Where would like your dental health to be?
1 2 3 4 5 6 7 8 9 10

When was the last time you had an oral cancer exam?_____ Date of last cleaning_____

If there was a way to whiten your teeth for a very reasonable investment, would you be interested?_____

What is the most important thing to you about your future smile and dental health?_____
_____

What is the most important thing to you about your dental visit today?_____
_____

Design In Dentistry
7130 E. Co Rd.150 South
317-837-8900
Fax 317-837-8908

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient Signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form: Relationship to Patient _____Print Name_____Source of Authority_____

Design In Dentistry
7130 E. co. RD. 150 South
Avon, IN 46123
(317)837-8900

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my dental treatment and follow-up among the multiple dental care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal dental care operations such as quality assessments and physical certification.

CONSENT

CONSENT TO USE AND DISCLOSE HEALTH (DENTAL) INFORMATION

Pursuant to the requirements found in the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), we request your consent to the following possible scenarios. It is our office policy to require your reading and signing this consent form prior to dental treatment or consultation in our office. If you have any questions, please ask a staff member for clarification.

Please initial and date your consent to authorize Design In Dentistry/Dr. Gregg Svoma and staff for the following:

- _____ In the event that I am not available, I authorize Design In Dentistry's office to leave a message on an answering machine at home or work, and or leave a message with a person.
- _____ To have Design In Dentistry's office mail me a reminder post card with the time and date of my upcoming appointments.
- _____ To send claim forms to my insurance company for third party reimbursement payments to be sent to Design In Dentistry by mail or fax.
- _____ To send any information requested by the insurance company to assist in the insurance portion of payment for dental services rendered to me by mail, phone or fax.
- _____ In the event that Design In Dentistry needs to refer me to a specialist for further treatment or evaluation, I authorize the relaying of any such information as deemed necessary by mail, phone or fax.
- _____ In the event another Dentist requests copies of my x-rays and/or records, I authorize Design In Dentistry to send the documents as deemed necessary by mail, phone or fax.
- _____ In the event that a family member needs to be involved in my care treatment, or payment at Design In Dentistry's office, I authorize the communication of any information deemed necessary.
- _____ In the event that a pharmacy calls or faxes a request for information to fill a prescription for me, I authorize Design In Dentistry's office to relay any such information as deemed necessary.

FINANCIAL ALLIANCE AND APPOINTMENT AGREEMENT

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment at the time of you r treatment is considered a part of our commitment to our office.
In order for us to provide the best experience, and to help you fit the care you want into your budget, we offer the following options regarding payment. Please check which option would best suit your needs. Please understand that payment is due at the time of service.

Option A:	Cash_____ Check_____
Option B:	MasterCard_____ Visa_____
Option C:	Extended payment plans with credit approval_____

REGARDING INSURANCE

If you have dental insurance, we will help you maximize your benefits. We request that you pay your estimated portion plus the deductible on the day you receive treatment. We will allow up to 60 days for payment from your insurance carrier. After 60 days, we must ask that you intervene. At that time we will ask that you pay your balance and we will forward any insurance credits to you.

REGARDING APPOINTMENTS

In our effort to be fair to all our patients, we ask that you notify our office immediately should you have a conflict with your scheduled appointment. We do not want to postpone care for a patient who could use that time. Failure to contact the office or doctor with less than 48 hours notice may result in a charge of up to $50.

FINANCE CHARGE

I understand that any unpaid balance after 60 days will be charged a yearly finance charge of 18%, which is equal to 1.5% of my outstanding balance per month.
Patients initials _____

Should my account reach collection status 60 days and I make no effort to pay off my balance, my account will be assigned to a collection attorney or agency. If my account is assigned to a collection agency, I agree to pay the cost of collections which include the balance plus additional 50% fees, including courts costs and attorney fees incurred by this office.

Thank you for taking the time to read and understand our financial and appointment agreement. Our practice is committed to providing the best care for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

Patient Signature:_____Date:_____
Financial Coordinator:_____Date:_____