Welcome to Indiana Family Dentistry, LLC

INFORMATION

1 ABOUT YOU

Today's Date: ____ /____ /____

PATIENT NAME: _____
LAST FIRST MI.

What you prefer to be called: _____ Male Female

Birthdate: ____ /____ /____ Age: ____ SS# _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone# _____

Work Phone# _____ Ext: _____

Other Phone# _____

Email Address: _____

Referred by: _____

Employer: _____ How Long?: _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have any family members that are current patients?

YES NO Name _____

Do you have children? YES NO How Many? _____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS#: _____

Drivers License#: _____

Work Phone#: _____

Payment method: ( ) Cash ( ) Check

_____
Credit Card-Enter card # above (If accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

2 INSURANCE INFO

PRIMARY DENTAL INSURANCE

Co. Name _____

Address: _____

_____
CITY STATE ZIP

Phone#: _____

Insured's SS#: _____

Group# (Plan, Local, or Policy#) _____

Insured's Name: _____

Relation: _____ Birthdate: ____ /____ /____

Insured's Employer: _____

_____

SECONDARY DENTAL INSURANCE

Co. Name _____

Address: _____

_____
CITY STATE ZIP

Phone#: _____

Insured's SS#: _____

Group# (Plan, Local, or Policy#) _____

Insured's Name: _____

Relation: _____ Birthdate: ____ /____ /____

Insured's Employer: _____

_____

4 IN EVENT OF EMERGENCY

Who should we contact?: _____

Relation: _____

Home Phone#: _____

Work Phone#: _____

Who is your medical Doctor?: _____

M.D.'s Phone#: _____

PLEASE CONTINUE ON BACK ▶

5 DENTAL INFORMATION

Reason for today's visit: Exam Emergency Consultation

Are you in pain? No Yes How Long? _____

Please indicate ✓ any of the following problems:

Discomfort, clicking or popping in jaw	Lost/broken filling(s)	Broken/chipped tooth
Red, swollen or bleeding gums	Teeth grinding	Stained teeth
Sensitive tooth, teeth or gums	Ringing in ears	Locking jaw
Bad breath	Blisters/sores in or around mouth	

Other(s): _____

Do you require pre-medication? Yes No Don't Know

Previous Dentist _____ (_____) _____
Name Phone#

Last Dental exam: _____ /_____ /_____ Last Dental X-rays: _____ /_____ /_____

Times per day you brush? _____ Times per week you floss? _____

What type of tooth brush bristles do you use? Soft Medium Hard

How would you rate your smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

6 MEDICAL HISTORY

IF YOU HAVE OR (HAVE BEEN TOLD YOU HAVE) ANY OF THE FOLLOWING, PLEASE CHECK Y OR N.

Chest Pains ☐Y☐N	Epilepsy / Seizures / Fainting ☐Y☐N	Artificial Joints / Implants ☐Y☐N
Heart Attack / Stroke ☐Y☐N	Drug Allergy ☐Y☐N	TMJ / TMD / Jaw Problems ☐Y☐N
Pacemaker / Artificial Valves ☐Y☐N	Arthritis / Rheumatism ☐Y☐N	Asthma / Emphysema ☐Y☐N
Congenital Heart Defect ☐Y☐N	Headaches / Neck Pain ☐Y☐N	Tuberculosis TB ☐Y☐N
Heart Disease ☐Y☐N	Glaucoma ☐Y☐N	Bleeding Problems ☐Y☐N
Mitral Valve Prolapse ☐Y☐N	Drug / Alcohol Treatment ☐Y☐N	HIV / AIDS / ARC ☐Y☐N
Nephritis / Kidney Disease ☐Y☐N	Ulcer / Stomach / Irritable Bow ☐Y☐N	High / Low Blood Pressure ☐Y☐N
Have you taken Bisphosphonates ☐Y☐N	Need Antibiotic b/f treatment ☐Y☐N	Thyroid Conditions ☐Y☐N
Hepatitis B C D / Liver Disease ☐Y☐N	Radiation / Chemo / Therapy ☐Y☐N	Do You Smoke or Chew ☐Y☐N
STD's ☐Y☐N	Cancer / Tumor ☐Y☐N	Do you Drink Alcohol ☐Y☐N
Diabetes / Hypoglycemia ☐Y☐N	Frequent Sore Throat ☐Y☐N	Cold Sores / Herpes / Shingles ☐Y☐N

Please list any other medical condition(s) you have or ever had: _____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

Pain Medication ☐Y☐N	Muscle Relaxers ☐Y☐N	Stimulants ☐Y☐N
Blood Thinners ☐Y☐N	Tranquilizers ☐Y☐N	Insulin ☐Y☐N

Others: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Latex ☐Y☐N	Aspirin ☐Y☐N	Sulfa ☐Y☐N
Penicillin / Amoxicillin ☐Y☐N	Dental Anesthetics ☐Y☐N	Other: _____

FOR WOMEN:

Are you taking Birth Control Pills ☐Y☐N	Are you pregnant ☐Y☐N	Are you nursing ☐Y☐N

7 INDIANA FAMILY DENTISTRY, LLC PATIENT CONSENT

The undersigned hereby authorizes the treating Dentists, employed by Indiana Family Dentistry, L.L.C. to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to preform any and all forms of treatment, medication

and therapy, that may be indicated in connection with (name of Patient) _____
and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% Annually) will be added to any balance over 80 days. In the event of default (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient: _____ Date: _____ Witness: _____

If Patient is Minor, Signature
of Responsible Party or Parent _____ Relationship to Patient: _____

INSURANCE ASSIGNMENT:

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

Signed: _____ Date: _____