PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____

Email_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

Check box if same for entire family [ ]

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments:

Patient Name: _____

DENTAL HISTORY

Date of:

- **Last cleaning** ___/___
- **Last oral cancer screening** ___/___
- **Last complete X-rays** ___/___

Name of previous Dentist: _____

City/State: _____

	Y	N
Interested in whiter teeth:	□	□
Interested in replacing metal fillings:	□	□
Interested in Braces/Orthodontics:	□	□
Interested in replacing missing teeth:	□	□

	Y	N
Tobacco use	□	□
Jaw joint pain	□	□
Grinding/clenching teeth	□	□
Loose/shifting teeth	□	□
Bleeding/swollen/painful gums	□	□

Have you ever had:

Denture	□	□
Partial denture	□	□
Periodontal therapy/deep cleaning	□	□
Braces	□	□

MEDICAL HISTORY

	Y	N
Heart Conditions	□	□
Angina (chest pain)	□	□
Artificial Heart Valve	□	□
Pacemaker	□	□
Endocarditis (heart infection)	□	□
Rheumatic Fever	□	□
Mitral Valve Prolapse	□	□
Heart Murmur	□	□
Heart Surgery	□	□
Heart Stent	□	□
Low blood pressure	□	□
High blood pressure	□	□
Blood Thinners	□	□
Anemia	□	□
Asthma	□	□
COPD	□	□
Chronic Bronchitis	□	□
Emphysema	□	□
Sleep Apnea	□	□
Sinus Problems	□	□
Diabetes	□	□
Stroke	□	□
Thyroid Disease	□	□
Blood Disease	□	□
Cortisone Medication	□	□
Seizures/Epilepsy	□	□
Glaucoma	□	□
Kidney Disease	□	□
Liver Disease	□	□
Stomach Problems	□	□
Stomach Ulcers	□	□
Arthritis	□	□
Artificial Joints	□	□

	Y	N
AIDS	□	□
HIV	□	□
Hepatitis B	□	□
Hepatitis C	□	□
HPV	□	□
STDs	□	□
Tuberculosis	□	□
Anxiety	□	□
Depression	□	□
Cancer	□	□
Cervical Cancer	□	□
Chemotherapy	□	□
Radiation Therapy	□	□
Currently Pregnant	□	□
Drug Addiction	□	□

***Other Conditions** _____

_____

ALLERGIES

	Y	N
Aspirin	□	□
Tylenol	□	□
Ibuprofen (NSAIDS)	□	□
Codeine	□	□
Morphine	□	□
Local Anesthetic	□	□
Nitrous Oxide	□	□
Latex	□	□
Valium	□	□
Penicillin	□	□
Sulfa	□	□
Erythromycin	□	□
Tetracycline	□	□

Other _____

MEDICATIONS (Please list all medications you are currently taking)

_____

_____

_____

Have you ever taken any medication for Osteopenia/Osteoporosis or Bone Disease, including any of the following medications? (please circle)

Actonel, Aredia, Boniva, Fosamax, Reclast, Zometa, other_____

Current Primary Care Physician: _____

Phone Number: _____

CONSENT: The undersigned hereby authorizes Doctor 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/health needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand the use of anesthetics embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

_____ _____

Patient Signature Date

FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I agree to inform the office with a 24 hour notice if I am unable to keep my appointment.
* Treatment plans may change, and I will be responsible for the work actually done.

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

APPOINTMENT POLICY

Our goal is to provide quality dental care to all of our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our provider, but our other patients as well.

* If you need to cancel your appointment, please call us as soon as possible. If you cannot reach a scheduling coordinator, please leave a detailed message.
* We will reach out to you two weeks prior to your appointment as a reminder call.
* We will call two days before your appointment to confirm, if we do not receive a confirmation call within 24 hours, we reserve the right to cancel your appointment.
* After three (3) failed appointments, we will be unable to schedule you for future appointments and you will be added to a Same Day List.

I have read and understand all of the above information regarding Center Grove Family Dentistry’s financial agreement, privacy policies, and appointment policy.

Signature_____ Date_____

Center Grove Family Dentistry

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I,_____, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results, date of services.

- Sensitive Protected Health Information (HIV- related information)
- You may disclose information to my family members and/or non-family members

Please list the name, phone number and relationship

NAME PHONE NUMBER RELATIONSHIP

_____

_____

_____

_____

- You may leave Protected Health Information on my answering machine/voicemail: Phone Number_____
- You may email me (unencrypted) for dental appointments: Email Address:_____

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

(Patient's Signature (or Guardian, if minor)

Date:_____