PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PATIENT OR PARENT'S EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

IF PT IS A STUDENT, NAME OF SCHOOL _____

CITY _____ STATE _____

WHO MAY WE THANK FOR REFERRING YOU? _____

_____

CONFIDENTIAL

BIRTHDATE _____

HOME PHONE _____

CIRCLE APPROPRIATE SELECTION:

MINOR SINGLE MARRIED

DIVORCED WIDOWED SEPARATED

WORK PHONE _____

CELL PHONE _____

OTHER _____

EMAIL _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

BIRTHDATE _____

SS NUMBER _____

INSURANCE INFORMATION

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

BIRTHDATE _____

SS NUMBER _____

GROUP NUMBER _____

INSURANCE PHONE _____

PATIENT NAME _____ PAGE 2

ADDITIONAL INSURANCE

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

INSURANCE COMPANY _____ BIRTHDATE _____

ADDRESS _____ SS NUMBER _____

CITY _____ STATE _____ ZIP _____ GROUP NUMBER _____

INSURANCE PHONE _____

PATIENT MEDICAL HISTORY

PHYSICIAN NAME _____ PHYSICIAN PHONE _____

- ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO
- HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS? YES NO
- ARE YOU TAKING MEDICATIONS? INCLUDING OVER-THE-COUNTER AND PRESCRIPTION. YES NO
- DO YOU USE TOBACCO DAILY? YES NO
- DO YOU USE ALCOHOL DAILY? YES NO
- DO YOU USE RECREATIONAL/STREET DRUGS? YES NO
- DO YOU HAVE ANY ALLERGIES? YES NO

  _____

  _____
- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

EXPLAIN ANY 'YES' ANSWERS: _____

_____

_____

DATE OF LAST EXAM _____

PHARMACY _____

_____

WOMEN ONLY, ARE YOU:

PREGNANT? YES NO

IF YES, _____MONTHS

NURSING? YES NO

TAKING BIRTH CONTROL? YES NO

PLEASE ANSWER THE FOLLOWING FOR YOURSELF (***MARK YES OR NO)***

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	THYROID DISEASE	___	___	AIDS/HIV INFECTION	___	___
HEART ATTACK	___	___	ANEMIA	___	___	STDs	___	___
RHEUMATIC FEVER	___	___	EMPHYSEMA	___	___	HEPATITIS A, B OR C	___	___
SWOLLEN ANKLES	___	___	CANCER/LEUKEMIA	___	___	ULCERS	___	___
FAINTING/SEIZURES	___	___	ARTHRITIS	___	___	RESPIRATORY PROBLEMS	___	___
ASTHMA	___	___	JOINT REPLACEMENT	___	___	OTHER _____		
LOW BLOOD PRESSURE	___	___	CHEST PAINS	___	___	_____		
EPILEPSY/CONVULSIONS	___	___	SHORT OF BREATH	___	___	_____		
KIDNEY DISEASE	___	___	STROKE	___	___	_____		
DIABETES	___	___	HAY FEVER/ALLERGIES	___	___	_____		
HEART DISEASE	___	___	TUBERCULOSIS	___	___	_____		
CARDIAC PACEMAKER	___	___	RADIATION THERAPY	___	___			
HEART MURMUR	___	___	GLAUCOMA	___	___			
ANGINA	___	___	LIVER DISEASE	___	___			

PATIENT NAME _____ **PAGE 3**

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	____	____
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	____	____
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	____	____
4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	____	____
5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH?	____	____
6. HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE, MOUTH, OR JAW?	____	____
7. DOES YOUR JAW EVER CLICK, POP, OR ACHE?	____	____
8. DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR, OR SIDE OF THE FACE?	____	____
9. DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH?	____	____
10. DO YOU HAVE DIFFICULTY CHEWING?	____	____
11. DO YOU HAVE FREQUENT HEADACHES?	____	____
12. DO YOU CLENCH OR GRIND YOUR TEETH?	____	____
13. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	____	____
14. HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK?	____	____
15. HAVE YOU EVER HAD BRACES?	____	____
16. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH?	_____	
17. HOW OFTEN DO YOU FLOSS?	_____	
18. DO YOU USE A MANUAL BRUSH OR ELECTRIC?	_____	
19. IS YOUR TOOTHBRUSH SOFT, MEDIUM, OR HARD?	_____	
20. IF YOU USE MOUTH RINSE, WHAT BRAND?	_____	

GOALS FOR YOUR MOUTH, TEETH AND SMILE: _____

_____

_____

_____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

_____ _____
PATIENT SIGNATURE DATE

_____
PRINT NAME

_____
DENTIST SIGNATURE

_____
DATE

_____
WITNESS SIGNATURE

_____
DATE

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- For patients with Dental Insurance:
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 24-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $50, or no reappointment. If more than one family member is scheduled & fails to make their appointment, an $50 cancellation fee will be assessed for the first individual and $40 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**
- Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you due to change in your contact information, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- Treatment appointments made that **exceed $500.00 will require 10% down** to hold the appointed time.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor before my next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

_____ _____

Signature (Patient, Parent or Guardian) Date

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 972-779-0300

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked at any time with a written request. Indigo Dentistry does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Indigo Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Indigo Dentistry

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Indigo Dentistry occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

Patient Name(printed)_____

Signature_____ Date_____