Today's Date _______________

REGISTRATION

First Name:______________________ **Last Name:**________________ **Middle Initial:**______ **Preferred Name:**_______________

Address:____ **City:**_________________ **State/Zip:**___________________

Phone: ____________________ **ext:** ____ **Cell:**___________________ ☐ **I am ok with receiving correspondence via text message**

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Seperated ☐ Widowed

Birth Date: ___/___/_____ **Social Security #:**__________________ **Drivers License:**_________________________________

Email: ____ ☐ **I would like to receive correspondences via e-mail.**

Employment Status: ☐ Full time ☐ Part time ☐ Retired **Student Status:** ☐ Full time ☐ Part time

Responsible party (if other than the patient):

First Name:______________________ **Last Name:**________________ **Middle Initial:**______ **Preferred Name:**_______________

Address:____ **City:**_________________

State/Zip:___________________

Phone: ____________________ **ext:** ____ **Cell:**___________________ ☐ **I am ok with receiving correspondence via text message**

Birth Date: ___/___/_____ **Social Security:**__________________

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information **ID #**___________________ **Group #**______________________

Name of Insured:______________________________ **Relationship to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: ______________________________ Insured Birth Date: ____/____/________

Employer: ____________________________________ Insurance Company: ____________________________________

Address:______________________________ Address:_______________________________________

City, State, Zip__________________________ City, State, Zip__________________________________

Secondary Insurance Information **ID #**___________________ **Group #**______________________

Name of Insured:______________________________ **Relationship to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: ______________________________ Insured Birth Date: ____/____/________

Employer: ________________ Insurance Company: ___________________________________

Address:______________________________ Address:_______________________________________

City, State, Zip__________________________ City, State, Zip__________________________________

INDY DENTAL HEALTH

Patient Name:____________________ Today's Date __________

MEDICAL HISTORY

Do you have an allergic (or adverse) reaction to any medications or substances? Please check below:

• Aspirin • Penicillin • Codeine • Sulfa • Latex Rubber • Metal • Acrylic • Local Anesthetics • Other: ____________________

Smoker/Tobacco use? ☐ Yes ☐ No How much/frequent? ____________

WOMEN: • Pregnant/trying to get pregnant • Nursing • Taking oral contraceptives

Do you have any artificial joints? ☐ Yes ☐ No

Do you have an artificial heart valve? ☐ Yes ☐ No

Do you require an antibiotic pre-medication before your dental visit? ☐ Yes ☐ No

Do you take or have you taken bisphosphonates? i.e., Boniva, Fosamax, Reclast, Actonel ☐ Yes ☐ No

Do you take or have you taken Phen-Fen or Redux? ☐ Yes ☐ No **If yes: did you have a medical exam for heart issues?** ☐Yes ☐No

Are you taking any medications, pills or drugs? ☐ Yes ☐ No Please list ______________________________

____

____

Name of Primary Care Physician: ______________________________ **Phone:** ____________________

Preferred Pharmacy______________________________

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

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

Do you have any health problems not listed above? ☐ Yes ☐ No If yes, please explain: ____________________

____

INDY DENTAL HEALTH

Patient Name:____________________ Today's Date _____________

DENTAL HISTORY

1. Please rate your dental health from 1 (poor) – 10 (best) ________
2. When was your last dental visit? ___________________ last dental cleaning? _______________________
3. Would you like to keep your teeth all of your life • *Yes* • *No*
4. Do you have a specific dental problem? • *Yes* • *No* Describe ______________________________________
5. Does any of the following cause tooth discomfort? • *Hot* • *Cold* • *Sweets* • *Chewing*
6. Do you have specific concerns about your **comfort** during dental treatment? • *Yes* • *No*
   If so, what? ____
7. Would you like to enhance your smile? • *Yes* • *No* How?____
9. How often do you brush and floss your teeth? ____
10. Do your gums bleed while cleaning or feel tender or swollen? • *Yes* • *No*
12. Does food catch between your teeth? • *Yes* • *No*
13. Do you clench or grind your teeth • *Yes* • *No*
14. Do you ever have jaw pain? • *Yes* • *No*
20. Have you had previous orthodontic treatment? • *Yes* • *No* If yes: when/previous doctor's name: _______________
21. Do you have any of the following habits?
   • *Finger/Thumb Sucking* • *Lip Biting* • *Nail Biting* • *Ice Chewing* • *Gum Chewing* • *Holding foreign objects in teeth (pencil, pipe)*

WELLNESS

23. Do you have any problems with sleep, such as:
   Insomnia: • *Yes* • *No* *Less than 7 hours a night:* • *Yes* • *No* *Sleep Disturbances:* • *Yes* • *No*
   Not refreshing or restful: • *Yes* • *No* *Other:* ____________________________
24. Has anyone ever told you that you snore? • *Yes* • *No* If so, is it bothersome to your bed partner? • *Yes* • *No*
25. Do you experience fatigue during the day and have difficulty staying awake? • *Yes* • *No*
31. Have you ever had previous sleep diagnoses or treatment? • *Yes* • *No* If yes, what was the treatment?
32. Have you ever had a sports injury, major or minor car accident, and/or trauma to your head or neck?
   • *Yes* • *No* *When and what?* ____

To the best of my knowledge, all of the preceding answers are correct. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. If I have any changes in my health status or if my medicines change, it's my responsibility to inform the dentist and staff at the next appointment.

Patient/Parent/Guardian Signature_______________________________________ Date______________________________

History Review:

Dentist Signature_______________________________ Date_____________

INDY DENTAL HEALTH

Office Financial Policy

- We try to make your dental care as cost-efficient as possible. One measure we have taken to keep cost down is to minimize our billing and accounting; therefore, we ask for payment at the time of service. Financial arrangements must be established before our office can proceed with any recommended treatment.

- All patients who are seen in our office for a Comprehensive Exam are provided with a Treatment Plan. This is an ESTIMATE of the anticipated cost of your dental treatment. Your Treatment Plan will include an estimated insurance payment based on your dental coverage. If your carrier's payment differs from our ESTIMATE, you are responsible for the balance. In the case of an overpayment, you are entitled to a prompt refund. Any claims over 30 days, become your responsibility.

- If after insurance pays, there remains a balance on your account, you will receive a *Statement for Services*. This is due and payable 30 days after receiving a statement. We will continue to send a statement each month until the balance of your account is paid in full. Should your account become delinquent (past due), we will continue to send a statement until the balance is over 90 days old. If your account remains delinquent, a letter will be sent in order to avoid the necessity of pursing further collections actions. Should your account remain delinquent, we will forward the balance to our collection agency. Patient understands and acknowledges, the patient will be responsible for all costs of collection, including attorney fees, and court cost, should additional means of collection be required.

- **Cancellation Policy**: If it becomes necessary to reschedule your appointment, we request the courtesy of **48 hours** notice. If you cancel, do not show or miss your appointment without the required notice, charges may be incurred to your account. This fee is strictly enforced and will not be covered by your insurance.

- If you have any questions regarding your account balance or if you are experiencing circumstances beyond your control, please contact our office.

Our practice firmly believes that a good doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication. We have instructed our staff to make every effort to clarify any misunderstandings you may have concerning your account balance or our financial policies. We hope to avoid any possible disagreements over payment for professional services.

Our patients and our relationships with our patients are very important to us. If you have any questions or need assistance, please contact us immediately.

Patient Signature ______________________________________ Date__________________