

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form
completely in ink. If you have any questions or need assistance, please ask us -
we will be happy to help.

Patient Information (CONFIDENTIAL)

Patient # _____
SS#/SIN _____
Date _____
Name _____ Birthdate _____ Home Phone _____
State/ Zip/
Address _____ City _____ Prov. _____ P. C. _____
Email _____ Cell Phone _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/ Zip/ _____
Prov. _____ ☐ Full ☐ Part
Patient or Parent/Guardian's Employer _____ Work Phone _____
State/ Zip/ _____
Business Address _____ City _____ Prov. _____ P. C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License# _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
State/ Zip/ _____
Address of Employer _____ City _____ Prov. _____ P. C. _____
Insurance Company _____ Group# _____ Policy/ID# _____
State/ Zip/ _____
Ins. Co. Address _____ City _____ Prov. _____ P. C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
State/ Zip/ _____
Address of Employer _____ City _____ Prov. _____ P. C. _____
Insurance Company _____ Group# _____ Policy/ID# _____
State/ Zip/ _____
Ins. Co. Address _____ City _____ Prov. _____ P. C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?		
If yes, please explain _____			Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have or have you had any of the following?			Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
			Other (please list) _____		
			12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 wks.)	<input type="checkbox"/>	<input type="checkbox"/>
			13. Women Only:		
			a) Are you pregnant or think you may be pregnant? ..	<input type="checkbox"/>	<input type="checkbox"/>
			b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
			c) Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant ..	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease ..	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (or parent/guardian if minor) _____

Doctor's Comments _____

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information and can will be used to :

- conduct, plan, and direct my treatment among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- obtain payment from third party payers.
- conduct normal healthcare operations such as quality assessments and physician certification.

I understand that a copy of the NOTICE OF PRIVACY PRACTICES contains a more complete description of the uses and disclosures of my health information and is available to read at Christie Family Dentistry. I understand that this organization has the right to change the NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time to obtain a current copy of the notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not require to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Christie Family Dentistry
2628 Western Avenue
Connersville In, 47331

Thank you for choosing our practice for your dental needs. We are committed to providing you with the best overall care. This includes proper and timely handling and filing of your insurance claims. However, you must realize your insurance is a contract between you, your employer, and the insurance company. It is your responsibility to furnish COMPLETE insurance information at the time of your appointment. Without the complete insurance information, we will be unable to properly file your claim and therefore, you will be responsible for the entire bill at the time of your appointment. Our office will do everything possible to assist you and your insurance company in processing your claim. This usually will ensure timely processing of your claim and prompt payment of the account. It has been our experience that those patients who are pro-active with their insurance company experience little difficulty in having the claim paid.

Once the account is 90 days over the date of service, we will expect payment in full by the person who signed financial responsibility for the account. If you have questions regarding this policy, feel free to speak to us. We offer financing through Care Credit. Please ask for a brochure/application if you would like to learn more.

In consideration of the services provided to the patient, I/we hereby guarantee payment of co-pay on the date of service, and the balance to be paid in full within 30 days from the payment of insurance. I/we agree that in the event of default of payment, reasonable collection agency fees, and/or reasonable attorney fees shall be added to the amount due on the account, plus any applicable court costs.

I understand the above and am aware that I am responsible for this entire account, not my insurance company, although the insurance company may pay a portion of the fee charged.

Signature of patient or Responsible Party

Date