CONFIDENTIAL

Patient Registration Information

Date:_____

Name_____ Patient# _____
First Mi Last

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance - we will be happy to help!

Home address _____ City _____ State/Prov. _____ Zip/P.C. _____

Birthdate _____ Home Phone _____ Work Phone _____

E-mail _____ Cell Phone _____

Do you prefer to receive calls at: ❑ Work ❑ Home ❑ Either

Are you ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

You or your parent/guardian's employer _____ Occupation _____

Business address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Spouse or parent/guardian's name _____ Employer _____ Work phone _____

If you are a student, name of school/college _____ City _____ State/ Prov. _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

City _____ State/ Prov. _____ Zip/ P.C. _____ *SS/SIN _____

Driver's license # _____ Birthdate _____ Financial Institution _____

E-Mail _____ Cell Phone _____

Employer _____ Work phone _____

Is this person currently a patient in our office? ❑ Yes ❑ No

Insurance Information

Name of insured _____

Relationship to patient _____

Birthdate _____ *SS/SIN _____ Date employed _____

Employer _____ Work phone _____

Address of employer _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Insurance company _____ Group # _____ Employer/cert. # _____

Ins. co. address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Please Continue... ☞

Financial Policy for Our Patients

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the 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 on behalf of my dependents.

I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balance.

Signature _____ Date _____

Our office wants all our patients to be able to comfortably afford dental care. We proudly offer the following financial policy so that our patients can have the opportunity to decide which payment option best suits your needs:

Insurance: *Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Because of this, you will be asked to pay your deductible and your co-payment for charges on the day the service is rendered. We will estimate as closely as possible your coverage,* ***but we can make no guarantee of any estimated coverage****. Because the insurance policy is an agreement between you and your insurance company, the ultimate responsibility for all charges lies with you. If after 60 days the insurance company has not paid on the claim, you will be responsible for the total balance.*

Payment Options:

1. ***Cash or Check.***
2. ***Credit Card.*** *Our office accepts VISA, MasterCard, and Discover.*

7 Days Family Dental
7007 US 31 S.
Indianapolis, IN 46227
(317) 893-2700

MEDICAL HISTORY

ALL INFORMATION IS HELD IN STRICT CONFIDENTIALITY

Date: _____

Name	Birthdate	Height	Weight
Physician	Physician's Address		Physician's Phone#
Are you being treated for any medical condition at this time? ___yes ___no	If yes, please explain below:		Date of last physical

Since your overall health may influence dental treatment, please answer the following questions by marking the appropriate lines. Clarifying or additional information may be written in the spaces to the side.

Have you ever had:

Yes	No		Yes	No	
		Headaches			Diabetes
		Seizures or epilepsy			Thyroid disorder
		Brain damage			More than 10 lbs. weight gain or loss in 6 mos.
		Head injury			Any other endocrine (glandular) disorder
		Glaucoma			
		Eye or ear problems			Skin problems (hives, rash, sores)
		Any other central nervous system disorder			Arthritis
					Inflammatory rheumatism
		Hepatitis			Joint prosthesis
		Jaundice			Any other skin, joint, or muscular disorder
		Ulcer or colitis			
		Any other stomach, intestinal, or liver disorder			Fever blisters
					Cancer or tumor
		Heart disease			X-ray treatment or surgery for tumor or growth on head or neck
		Hardening of the arteries			Venereal disease
		Stroke			HIV+
		Rheumatic fever			Night sweats
		Heart murmur			Psychiatric treatment
		Congenital defect			
		Mitrovalve prolapse			Allergic reaction to:
		Heart prosthesis			Local anesthetic ("novocaine")
		Abnormal bleeding			Penicillin
		Hemophilia, anemia, leukemia			Other antibiotics _____
		High blood pressure			Codeine
		Any other heart, blood, or circulatory disorder			Aspirin
					Other drugs _____
		Chronic cough			Other allergies _____
		Tuberculosis			
		Asthma			Women:
		Pneumonia			Are you pregnant? Due Date _____
		Frequent colds or bronchitis			Are you nursing?
		Do you smoke?			
		Any other respiratory disorder			Is there any other condition or illness that
					could influence your dental treatment?
		Bladder or kidney infection			
		Kidney disease			
		Any other bladder or kidney disorder			**Turn page over. . .**

Hospitalizations:		Medications currently taking:
Date	Reason	(prescription & non-prescription)

Dental History:

Yes	No	For all patients:
		Is this your first dental visit ever?
		If no, when was last visit?
		What treatment was done?
		Have you ever had an unpleasant dental experience?
		If yes, explain:
		How frequently do you brush your teeth?
		Texture of brush used?
		Do your gums bleed when you brush?
		How frequently do you floss your teeth?
		For child patients:
		Has your child ever had an injury to the mouth, teeth or jaws?
		When?
		How?
		Has your child ever sucked his/her thumb, finger, or pacifier?
		Beginning when?
		Ending when?
		Is brushing supervised or assisted? (For children 8 yrs. old or younger)
		For denture patients:
		How long have you worn a denture?
		How long have you had your present denture?
		Do you remove your denture when you sleep?

Our office wants all patients to be able to comfortably afford dental care. Beginning March 1, 2010 we will offer the following financial policy so that our patients can have the opportunity to decide which payments option best suits your needs:

- **Insurance**: Our policy will gladly work with to help to get the maximum benefit available to you. **Most dental insurance plans do not cover 100% of your cost of treatment. Because of this, you will be asked to pay your deductible and your co-payments for charges on the same day of service are rendered. We will estimate as closely as possible your coverage, but we can make no guarantee of any estimated coverage.** Because the insurance policy is an agreement between you and your insurance company, the ultimate responsibility for all charges lies with you. If after 60 days the insurance company has not paid on the claim, you will be responsible for the total balance.
- **Payment Options:**
  1. **Cash or Check**
  2. **Credit card**. We accept Visa, MasterCard, Discover, and American Express.
  3. **Outside Financing**: Care Credit. A dental credit card with an outside financing company that can be applied for through our office. The application is called in from or office or online. We can get an answer within minutes if the applicant is approved. This is a 6 or 12 month deferred interest card with payments being made directly to Care Credit

- **Beginning March 1, 2010 all appointments broken without adequate advance notifications (24 hour business notice) a fee will be charged. This fee must be paid in full prior to being rescheduled. Please keep in mind that any appointment failed or cancelled on short notice leaves a serious void in our schedule that could have been used for another patient in need. We feel strongly that we are best able to serve you and other patients when the time we have set aside in our schedule jus for you are maintained. We value you as a patient and want to provide you with optimal dental care.**

Sign _____ Date_____

NAME OF OFFICE: 7 Days Family Dental

ADDRESS OF OFFICE: 7007 US 31 S.
Indianapolis, IN 46227
(317) 893-2700

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, _____, Date of Birth _____, 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 leave me a text message: Text Phone Number: _____
- ○ You may email me (unencrypted) for dental appointments:
  Email Address: _____
- ○ You may fax me for dental information: Fax Number: _____
- ○ Other: _____

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

Print Name: _____

Signature: _____

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

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please specify)