Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from patient)* _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address *(if different from patient)* _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑Y ❑N Bad breath
❑Y ❑N Bleeding gums
❑Y ❑N Clicking or popping jaw
❑Y ❑N Food collection between teeth
❑Y ❑N Grinding or clenching teeth
❑Y ❑N Loose teeth or broken fillings
❑Y ❑N Periodontal treatment
❑Y ❑N Sensitivity to cold
❑Y ❑N Sensitivity to hot
❑Y ❑N Sensitivity to sweets
❑Y ❑N Sensitivity when biting
❑Y ❑N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑Y ❑N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑Y ❑N

If yes, describe _____

Are you currently under physician care? ❑Y ❑N If yes, describe _____

Have you ever had a blood transfusion? ❑Y ❑N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑Y ❑N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑Y ❑N

Women: Are you pregnant? ❑Y ❑N Nursing? ❑Y ❑N Taking birth control pills? ❑Y ❑N

Check (✓) yes or no whether you have had any of the following:

❑Y ❑N AIDS/HIV Positive
❑Y ❑N Anaphylaxis
❑Y ❑N Anemia
❑Y ❑N Arthritis, Rheumatism
❑Y ❑N Artificial heart valves
❑Y ❑N Artificial joints
❑Y ❑N Asthma
❑Y ❑N Atopic (allergy prone)
❑Y ❑N Back problems
❑Y ❑N Blood disease
❑Y ❑N Cancer
❑Y ❑N Chemical dependency
❑Y ❑N Chemotherapy
❑Y ❑N Circulatory problems
❑Y ❑N Cortisone treatments
❑Y ❑N Cough, persistent
❑Y ❑N Cough up blood
❑Y ❑N Diabetes
❑Y ❑N Epilepsy
❑Y ❑N Fainting
❑Y ❑N Food allergies
❑Y ❑N Glaucoma
❑Y ❑N Headaches
❑Y ❑N Heart murmur
❑Y ❑N Heart problems
Describe _____
❑Y ❑N Hemophilia/ Abnormal bleeding
❑Y ❑N Herpes
❑Y ❑N Hepatitis
❑Y ❑N High blood pressure
❑Y ❑N Jaw pain
❑Y ❑N Kidney disease or malfunction
❑Y ❑N Liver disease
❑Y ❑N Material allergies (**latex**, wool, metal, chemicals)
❑Y ❑N Mitral valve prolapse
❑Y ❑N Nervous problems
❑Y ❑N Pacemaker/ Heart surgery
❑Y ❑N Psychiatric care
❑Y ❑N Rapid weight gain or loss
❑Y ❑N Radiation treatment
❑Y ❑N Respiratory disease
❑Y ❑N Rheumatic/Scarlet fever
❑Y ❑N Shingles
❑Y ❑N Shortness of breath
❑Y ❑N Skin rash
❑Y ❑N Spina Bifida
❑Y ❑N Stroke
❑Y ❑N Surgical implant
❑Y ❑N Swelling of feet or ankles
❑Y ❑N Thyroid disease or malfunction
❑Y ❑N Tobacco habit
❑Y ❑N Tonsillitis
❑Y ❑N Tuberculosis
❑Y ❑N Ulcer/Colitis
❑Y ❑N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Scot B. White D.D.S., P.C.
1717 East Main St.
Crawfordsville, IN 47933

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

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be in involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. Understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of *Notices and Privacy Practices.*

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 required 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_____

OFFICE USE ONLY

I attempted to obtain he patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement,* but was unable to do so as documented below.

Date_____Initials_____ Reason_____

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION "PHI"

This form will allow us to leave a message on voicemail or with individuals involved in your dental care

PATIENT INFORMATION

Name of Patient_____

Phone Number_____Other number_____

Date of Birth_____

I (the undersigned) hereby consent to **Scot B.White D.D.S.,P.C.**, leaving a voicemail message at the number(s) indicated above and/or discussing with the individual(s) listed below information related to my PHI. These communications may include, but are not limited to, appointment reminders, insurance, treatment plans and financial information

With my consent, Scot B. White D.D.S.,P.C. may discuss PHI with the following individuals:

Name_____ Date of Birth_____

Relationship_____

Name_____ Date of Birth_____

Relationship_____

Name_____ Date of Birth_____

Relationship_____

I understand I have the right to revoke this consent at any time in writing, but that revoking authorization will not affect disclosures made or actions taken before the revocation is received. This consent is valid for one year from the date of execution.

I further understand that this consent does not permit the release of my actual dental records to the individual(s) listed above. Such release will only be made if I sign a separate valid authorization.

_____

Signature of Patient, Guardian, Parent, or Healthcare Representative Date

Scot B. White D.D.S.,P.C.
Financial Responsibility Agreement

By signing below I guarantee that the information presented above is true and accurate.

By signing below I give permission for this office to submit information to the insurance(s) listed and to collect fees for services provided.

By signing below I agree that I am responsible for payment of all fees not paid by my insurance including but not limited to deductibles, copays, and disallowed services, any interest or fees assessed to my account for past due balance, returned checks, attorney fees, and all fees incurred as a result of the use of a collection agency.

Patient_____

Signature_____ Date_____
(parent if patient is a minor child)