8001 E. 10th Street - Indianapolis, IN 46219

PATIENT INFORMATION

PATIENT: First Name ___________________ Middle Initial ____ Last Name ___________________________

Sex: Male ☐ Female ☐ Date of Birth _______________ Age ______ Social Security # _________________

Home Phone (   ) _______________ Business Phone (   ) _______________ Cell (   ) _______________

Street _________________________________ City ____________________ State _____ Zip _____________

Email Address ____

Previous Dentist __________________ Referred By __________________ Physician ___________________

Student: Full Time ☐ Part Time ☐ Not ☐ School Name/Address __________________________________

Married ☐ Divorced ☐ Separated ☐ Widow ☐ Single ☐ Spouse Name ______________________________

Patient Employed: Full Time ☐ Part-Time ☐ Retired ☐ Not ☐ Employer Name ______________________

Who will be responsible for your account? Self ☐ Spouse ☐ Mother ☐ Father ☐ Other ________________

Spouse Name ____________________ Social Security # ______________Home Phone # (   ) ___________

Employer Name/Address ____ Phone # (   ) _______________

IN CASE OF EMERGENCY NOTIFY: Name ____________________________ Phone # (   ) _______________

MINOR OR FULL TIME STUDENT INFORMATION:

Father's Name ________________ DOB _____ Social Security # ___________ Home Phone # (   ) ________

Street _________________________________ City ____________________ State _____ Zip _____________

Employer Name/Address ____ Phone # (   ) _______________

Mother's Name ________________ DOB _____ Social Security # ___________ Home Phone # (   ) ________

Street _________________________________ City ____________________ State _____ Zip _____________

Employer Name/Address ____ Phone # (   ) _______________

I herby authorize the payment of the medical and/or dental benefits to Lily Dental for services provided.

Signature ____ Date ____________________

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PATIENT INFORMATION

INSURANCE INFORMATION

PRIMARY **DENTAL** INSURANCE:

Insurance Company ________________________

Employee Name ___________________________

Employee Birthdate ____________ SS#_______

Patient Relation To Employee:

☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Phone # (   ) _________________________

Group # _________ Insurance I.D. # ___________

Employer _________________________________

Bus. Phone # (   ) ___________________________

PRIMARY **MEDICAL** INSURANCE:

Insurance Company ________________________

Employee Name ___________________________

Employee Birthdate ____________ SS#_______

Patient Relation To Employee:

☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Phone # (   ) _________________________

Group # _________ Insurance I.D. # ___________

Employer _________________________________

Bus. Phone # (   ) ___________________________

SECONDARY **DENTAL** INSURANCE:

Insurance Company ________________________

Employee Name ___________________________

Employee Birthdate ____________ SS#_______

Patient Relation To Employee:

☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Phone # (   ) _________________________

Group # _________ Insurance I.D. # ___________

Employer _________________________________

Bus. Phone # (   ) ___________________________

SECONDARY **MEDICAL INSURANCE:**

Insurance Company ________________________

Employee Name ___________________________

Employee Birthdate ____________ SS#_______

Patient Relation To Employee:

☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Phone # (   ) _________________________

Group # _________ Insurance I.D. # ___________

Employer _________________________________

Bus. Phone # (   ) ___________________________

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Signature ____ Date ____________________

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

CONSENT FOR RELEASE OF DENTAL X-RAYS AND/OR DENTAL RECORDS

PATIENT GIVING CONSENT TO RELEASE DENTAL X-RAYS AND/OR DENTAL

RECORDS FROM: ____
(DOCTOR'S OFFICE NAME)

DOCTOR'S ADDRESS: ____

RELEASE TO: ____
(DOCTOR'S OFFICE NAME)

DOCTOR'S ADDRESS: ____

DOCTOR'S email: ____

PATIENT'S NAME: ____

ADDRESS: ____

TELEPHONE NUMBER: ____

SOCIAL SECURITY NUMBER: ____

PATIENT'S SIGNATURE: ______________________________ DATE: ____________

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HEALTH HISTORY

Patient Name ____ Date _________________________

To our patients:

As your dental practice, our primary concern is your oral health. Health problems you may have or medications you are taking can play an important role in the care you will be receiving. Thank you for answering the following questions.

	Yes	No
Are you in good health?........................ Height ___________ Weight________	☐	☐
Have there been any changes in your general health in the past year?..............	☐	☐
Are you under the care of a physician? .... Date of last visit ________	☐	☐
If so, for what are you being treated? _______________________________		
Have you had any illness, operation or been hospitalized in the past five years?	☐	☐
If so, describe ____		
Do you have unhealed injuries or inflamed areas in or around your mouth, growth or sore spots in your mouth?	☐	☐
If so, describe where ____________________________________		
Is the condition we are seeing you for today due to an accident?	☐	☐

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE………	YES	NO	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE………	YES	NO	NOTES
1	Rheumatic Fever?				1	Fainting spells?			
2	Damaged heart valves/mitral valve prolapse?				2	Convulsions, epilepsy?			
3	Heart murmur?				3	Thyroid trouble?			
4	High blood pressure?				4	Diabetes?			
5	Low blood pressure?				5	Low blood sugar?			
6	Stroke?				6	Kidney trouble?			
7	Chest pain, angina?				7	Are you on dialysis?			
8	Heart attack(s)?				8	Swollen ankles, arthritis or joint disease?			
9	Irregular heart beat?				9	Do you have an artificial joint?			
10	Cardiac pacemaker?				10	Stomach ulcers?			
11	Heart surgery?				11	Contagious diseases?			
12	Bronchitis, chronic cough?				12	Sexually transmitted diseases?			
13	Asthma?				13	AIDS or HIV infection?			
14	Hay Fever/sinus problems?				14	Problems of the immune system?			
15	Tuberculosis?				15	A tumor or growth?			
16	Emphysema?				16	Chemotherapy?			
17	Difficulty breathing?				17	Radiation therapy?			
18	Any other lung trouble?				18	Mental health problem?			
19	Do you smoke?				19	Contact lenses?			
20	Blood disorder such as anemia?				20	Eye disease/glaucoma?			
21	Bruise easily?				21	Pain & clicking of jaws when eating?			
22	Bleeding tendency (abnormal bleed)?				22	Malignant Hyperthermia?			
23	Blood transfusion?				23	Are you wearing a removable dental appliance?			
24	Jaundice, hepatitis or liver disease?				24	Are you on a diet?			
25	Infectious mononucleosis?				25	Habit-forming drugs?			
26	Gallbladder trouble?				26	Alcoholic beverages?			

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HEALTH HISTORY

ARE YOU TAKING ANY KIND OF MEDICINE, DRUG OR PILLS FOR ANY PURPOSE?

	YES	NO
Bisphosphonates (Fosomax, Boniva, Actonel)?..		
Tranquilizers?..		
Cortisone?...		
Other medications, including herbal supplements? (Please list)..		

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO:

	YES	NO
Local Anesthetics?...		
Penicillin or other antibiotics?..		
Sulfa Drugs?..		
Barbiturates, sedatives or sleeping pills?..		
Aspirin?..		
Iodine?..		
Codeine or other narcotics?...		
Other medications?...		
Allergies other than drug allergies? (please list?......Latex etc.................		

IS THERE ANY CONDITION CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD?_________________________________

WOMEN:

	YES	NO
Is there a possibility that you may be pregnant?...		
Estimated delivery date: __________________...		
Are you nursing?..		
*Are you taking birth control pills?..		

*_**PRECAUTION:** If an antibiotic is prescribed for you, and you are currently using a birth control method, please be aware that the drug prescribed may interfere with the effectiveness of your birth control. The result could be an unplanned or unexpected pregnancy. Discuss using other methods of birth control with your doctor._

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above are answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions I have made in the completion of this form.

Present Illness and Chief Complaint.

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CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

_______________________________________ Date of Birth ______________ request that the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis, test results, and dates of service.

PLEASE CHECK ALL THAT APPLY

You may disclose information to my family members and or non-family members. Please list name, phone number and relationship.

Name	Phone Number	Relationship

You may leave Protected Health Information on my answering machine/voicemail.

Phone Number: _____________________________________

Other: _____________________________________

____
Patient's Printed Name

____
Social Security Number

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

____
Date

____
Witness (Optional)

____
Date

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AGREEMENT TO FINANCIAL RESPONSIBILITIES

I understand that if collection efforts are deemed necessary, I will be responsible for reasonable collection costs, late fees, interest and attorney's fees.

If you don't have dental insurance, payment is expected at the time of your visit. All cosmetic procedures must be paid in full at the time of your appointment. Patients with insurance will be given a patient payment ***estimate*** at every visit and this amount is due at the time of your appointment. This is only an estimate and the final financial responsibility for you will be given after insurance payment has been received. We cannot guarantee payment of your claim by your insurance. As a courtesy, our office will mail out monthly statements of balances due. Should your account become delinquent and be placed with a collection agency, you will be responsible for collection fees equaling 30% of any unpaid balance placed for collection. Additionally, you will be responsible for interest at the rate of 10 % per year, all reasonable attorney fees, court costs, sheriff or service of process fees and any other reasonable costs of collection.

If your insurance company pays you directly, then it is your responsibility to pay your office per visit and then you can collect from your contracted insurance provider.

If you are covered under the Medicaid Program and agree to treatment that is above your yearly maximum then these fees will be your responsibility to pay at the time of service. On the same note, if you agree to a service that is not covered by Medicaid, payment will also be expected at time of service.

We accept Visa, Mastercard, Discover and American Express. We also offer payment options through CareCredit if desired. Please ask for information regarding this no interest/or low payment program.

If a check is returned to us for insufficient funds, an additional $30.00 fee will be applied to your account.

Our office also requires a 24 hour notice if you are unable to keep your scheduled appointment. A fee will be charged for missed/failed appointments that do not meet this requirement.

Signature: ____

Date: ______________________________