Date	Patient Information Chart			Chart#
Dr. Mr. Mrs. Ms.	Last	First	Preferred Name	Middle
Single Married Widowed Divorced Separated	Spouse's Name		Email	
Birth date	Age	Social Security#	Driver's License#	
Address		City	State	ZIP
Home Phone	Cell Phone		Ext.	Other
If Patient is under 18 yrs. old	Father's Name		Mother's Name	

Referral Information

Whom may we thank for referring you to our practice?

❑ Internet/Search Engine ☐ Yellow Pages Social Media ☐ Walk-in ☐ Other_____

☐Name of relative, patient, office, or other resource referring you to our practice: _____

Dental Health Information

Date of last dental visit: ____/___/_____ When was your last cleaning? ____/___/_____

What is your immediate dental concern?_____

Please check those that apply. They will enable us to determine your dental concerns.

Periodontics (gum disease)
- ❑ Red, swollen or tender gums
- ❑ Gums bleed with brushing/flossing
- ❑ Unpleasant odor or taste in your mouth

Endodontics (root canal therapy)
- ❑ Sensitivity to hot
- ❑ Sensitivity to cold
- ❑ Sensitivity to biting

Orthodontics (braces)
- ❑ Crooked or crowded teeth
- ❑ Bad bite
- ❑ Protruding teeth
- ❑ Impacted teeth

Cosmetic
- ❑ Dark or discolored teeth
- ❑ White spots
- ❑ Chips in teeth

Prosthodontics (false teeth)
- ❑ Missing teeth
- ❑ Loss of taste
- ❑ Broken or worn teeth
- ❑ Red gums around existing crowns or bridges

General Health Information

It is important that we know your dental and medical history. Many things have a direct bearing on your dental health. The doctor and staff will review this section and discuss things in detail. This information is strictly confidential and will not be released to anyone without your consent.

Do you have or ever had any of the following? Please check those that apply

General
- ❑ Tire easily, weakness
- ❑ Weight change
- ❑ Persistent fever
- ❑ ADD/ADHD
- ❑ Autism
- ❑ Behavioral Issues
- ❑ Cerebal Palsy
- ❑ Developmental delays

Sensory
- ❑ Rash/hives
- ❑ Change in skin color
- ❑ Glaucoma
- ❑ Visual Change
- ❑ Loss of hearing
- ❑ Ringing in ears
- ❑ Frequent nosebleeds
- ❑ Sinus problems

Nervous system
- ❑ Stroke
- ❑ Convulsions
- ❑ Headaches
- ❑ Epilepsy
- ❑ Numbness
- ❑ Tingling
- ❑ Dizziness
- ❑ Fainting
- ❑ Psychiatric Treatment
- ❑ Nervous disorders
- ❑ Seizures

Respiratory
- ❑ Tuberculosis
- ❑ Emphysema
- ❑ Asthma/Hay fever
- ❑ Persistent Cough
- ❑ Phlegm production
- ❑ Coughing up blood
- ❑ Difficulty breathing
- ❑ Sore/Hoarse throat

Endocrine
- ❑ Diabetes
- ❑ Family diabetes
- ❑ Thyroid condition
- ❑ Other

Heart/Blood Vessels
- ❑ Rheumatic fever
- ❑ Heart murmur
- ❑ Chest pain/discomfort
- ❑ Heart attack/trouble
- ❑ Shortness of breath
- ❑ Swelling of ankles
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Mitral valve prolapse
- ❑ Congenital heart disease
- ❑ Artificial heart valve
- ❑ Pacemaker
- ❑ Heart surgery
- ❑ Other

Bones/Muscles
- ❑ Arthritis/rheumatism
- ❑ Artificial joints/limbs
- ❑ Osteoporosis

Digestive System
- ❑ Hepatitis
- ❑ Jaundice
- ❑ Ulcers
- ❑ Change in appetite
- ❑ Liver disease
- ❑ Abnormal stool
- ❑ Stomach problems

Urinary
- ❑ Kidney disease
- ❑ Increased urination
- ❑ Burning on urination
- ❑ Urethral discharge
- ❑ Bloody urine
- ❑ Venereal disease

Blood
- ❑ Bruise easily
- ❑ Excessive bleeding
- ❑ Head injuries
- ❑ Anemia
- ❑ Blood transfusion
- ❑ HIV positive
- ❑ AIDS
- ❑ Sickle Cell Anemia

Other
- ❑ Chemotherapy
- ❑ Radiation therapy
- ❑ Tumors or growths
- ❑ Cancer
- ❑ Cold Sores
- ❑ Sexually Transmitted Disease
- ❑ Contact Lenses
- ❑ Mental disorders
- ❑ Smoker
- ❑ Non Smoker
- ❑ Gagger

Are you allergic to or have you acted adversely to any of the following? Please check those that apply.
- ❑ Antibiotics
- ❑ Aspirin
- ❑ Codeine/narcotics
- ❑ Ibuprofen
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Metals
- ❑ Penicillin
- ❑ Sedatives
- ❑ Sulfa
- ❑ Other_____
- ❑ None_____

If yes, what types of reactions were experienced? Hives Nausea Rash Respiratory problems Vomiting

Clinical Notes: (To be used by Doctor and Staff only.)

- Do you require premedication? Y or N If so, what medication(s)? _____ Did you take today? Y or N
- Are you currently under the care of physicians? Circle yes or no.
  If yes, please explain: _____
  Name/Phone of Clinic/Physicians: _____
  Are you up to date on immunizations? Y or N
- What was the date of your last complete physical? Date:____/_____/____Findings?_____
- Please explain any other health conditions that need further clarifications:_____

- Are you taking any of the following medications and if so, what is the name and dosage?

  - Antibiotics, penicillin, amoxicillin, or sulfa drugs?_____
  - Anticoagulants, blood thinning agents, coumadin, or aspirin daily?_____
  - Medicine for high blood pressure?_____
  - Codeine or other narcotics?_____
  - Cortisone or steroid drugs?_____
  - Thyroid medicine?_____
  - Antihistamine, allergy drugs, or cold remedies?_____
  - Vitamins, herbs, or over the counter drugs?_____
  - Recreational drugs or alcohol?_____
  - Insulin or diabetes medications?_____
  - Other?_____

- Have you been hospitalized or had a serious operation or illness within the past 5 years? _____
  _____

- For women (please circle Yes or No).
  - Are you: Pregnant? Yes/No Nursing? Yes/No Taking Birth Control? Yes/No Taking hormonal therapy? Yes/No

  What is the name of your obstetrician?_____ Phone Number:_____ Weeks Pregnant?___

To the best of my knowledge, the preceding information provided is correct. If I ever have a change in my health, insurance, emergency numbers, employment, address, responsible party, or medications, I will inform the practice at the next appointment.

_____ Date: _____/_____/_____
Signature of patient, parent or guardian

Emergency Numbers

In Case of an emergency notify (individual not residing at patient's address):

Relative's Name	Address
Phone Number	What is the relationship?

Responsible Party Information

The following is for the person responsible for payment

Dr. Mr. Mrs. Ms.	Last	First	M.I.
Single Married Widowed Divorced Separated	Birth date	Social Security#	
Address	City	State	ZIP
Home Phone	Work Phone	Ext.	Other
Responsible Party Signature			

Employment Information

The following is for the patient or person responsible for payment.

Employer Name		Occupation		
Address		City	State	ZIP
Work Phone	Ext.	Other		

Consent for Services

I agree to comply with the office's financial policy. I understand that a consultation is complimentary, however a fee applies when exams or x-rays are performed. I understand interest of 1.5 percent per month/18 percent per year will be charged on outstanding balances after 30days. I understand that I am responsible for reasonable attorney fees, court costs, and/or collection costs in the event of nonpayment or insufficient payment of my account, all without relief of the valuation and appraisement laws of the State of Indiana.For patients with insurance; I authorize my insurance company to make payment directly to the office. I will be responsible for any portion of the bill my insurance does not cover. I authorize the doctor to release to my insurance company any information obtained in the course of my examination or treatment. I understand that any treatment plan fees for dental care will be honored for a period of one month. We do not accept secondary insurance of any kind.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss (or leave messages) concerning matters related to this form and/or treatment. I authorize the office to assess my account a $25.00 dollar fee in the event that my dependant or I fail a scheduled appointment without 24-hour notification.

By signing this form, I consent to the practice's use and disclosure of my (my dependent's, my parent's) protected health information to carry out treatment, payment activities, and healthcare operations. I give consent for protected health information to be released to additional persons such as a spouse, guardian, grandparent, or caregiver for this patient.

_____

Signature of patient, parent, guardian, or caregiver _____ Date: ____/____/____

POLICIES

Welcome to Munster Distinctive Dentistry & Munster Distinctive Dentistry *just for kids*! We are delighted that you have chosen our dental practice for all of your family's oral healthcare needs! Our group of friendly and compassionate dentists, denturists, hygienists, dental and sterilization assistants and our patient care representatives all share a passion for excellence and a commitment to providing the highest level of care to our patients! Please take a minute to review the following information and policies that we've instituted to ensure that we streamline the check-in and check-out process for each visit.

REQUIRED ACCOUNT BILLING & SCHEDULING INFORMATION

A physical billing address; we cannot use a PO Box;
A copy of your driver license or state issued ID;
We will take your picture for our electronic charts & to protect you from identity theft;
Your e-mail address;
Your cell, home and work phone numbers;

OUR PAYMENT PROTOCOL:

For those patients not filing insurance claims, payment in full is expected prior to treatment. Cash, check, credit and debit cards are accepted.
If filing an insurance claim, you may pay in full or use ***EASY PAY*** for any amount not covered by your insurance plan. ***EASY PAY*** eliminates all post treatment bills! Much like checking into a hotel or renting a car, the first thing you're asked for is a credit card, which is kept on file and later used to pay your bill, making checkout easier, faster and more convenient. Our goal is your convenience and to streamline your future checkout after treatment. You provide a credit card of your choice and authorize us to use your ***EASY PAY*** credit card for any outstanding balances after insurance pays or 28 days from claim submission, whichever comes first. In the event your insurance carrier remits payment and your family balances are current, a refund will be issued. Debit cards are not eligible for the ***EASY PAY*** option.
If filing a MEDICAID claim, there may not be an out of pocket expense for covered procedures, however you have substantial limitations to coverage.
In the event you wish to consent to treatment not covered under your plan, we require a financial arrangement.
Costs exceeding $1,000 are eligible for *CARE CREDIT*™. No money down as low as $28 per $1000 financed. 24 to 60-month plans.

SECURITY We provide the highest degree of security of your personal information, and your credit card information securely stored from the first interaction at the point of sale up until the data reaches the secure payment processing environment.
WE ARE GREEN! We employ electronic billing. We also utilize email and text messaging to offer and confirm appointments and therefore require your cellphone number.

INSURANCE

All patients utilizing their insurance coverage are required to bring their current insurance cards to each visit. As a courtesy to our patients, we are happy to file your insurance claim for you to your primary insurance provider. We do not accept or file secondary insurance, although we may provide assistance to you if you wish to submit the forms on your own. All Dental Insurance is intended to cover some, but not all of the cost of your dental care. Dental plans may require that the patient pay coinsurance, a deductible, or other expenses. I understand that my insurance benefit is not a guarantee of payment. Any fees not covered by insurance will be the sole financial responsibility of the patient/guarantor. I am aware that every insurance plan is different and that I am responsible for understanding my personal dental insurance benefit. Insurance companies may mislead you and suggest that our fees are "above the usual and customary" rather than saying "their benefits are too low." Our fees are based on practice overhead, the selected treatment plan, and the time necessary to provide care. We do not see you as "usual and customary," but as a member of our family of patients for whom we provide the highest standard of care. The range of benefits you receive depends on the benefits your employer wishes to offer to their employees. Some plans are very poor and may cover as little as 10% of dental services; others as much as 80% of dental services, with most falling in the 30% to 60% range. The amount your plan pays is determined by how much you or your employer pays for the plan. Dental plans determine benefits on a schedule of fees arbitrarily chosen by the insurance company, driven by a profit motive, not your oral health care! For this reason, you may receive a lower percentage reimbursement than indicated in your dental plan. Therefore, if your plan states that it will pay 80% of the cost of dental care, what they really mean is 80% of the Insurance Company's fee schedule that is negotiated by and between your employer and the insurance company, and not 80% of the dentists' fee.Some dental services are covered only a specific number of times in a calendar year. For example, preventative cleaning may be covered only once a year. We do not believe it is in your best interest to compromise treatment to accommodate a dental insurance plan's limitations or to allow an insurance carrier to dictate your treatment or to interfere with our patient-doctor relationship. The treatment that you need is based upon professional judgment, and not whether you are covered by a dental benefits plan. The treatment you choose should and must be entirely your decision. Be assured that we will never provide usual, customary, or average service, but rather, the most professional, highest quality and comprehensive services available from a dental healthcare team. Our office will help you in every way in handling inquiries about your insurance, treatment plan, affordability and financial obligations.

PRETREATMENT ESTIMATES While we are happy to provide pre-treatment estimates of coverage for your insurance plan, please remember those are your insurance company estimates. **INSURANCE COMPANIES ARE NOT LEGALLY OBLIGATED TO PAY ANY PRE-TREATMENT ESTIMATES THEY PROVIDE. OUR PRACTICE HAS NO CONTROL IN HOW MUCH YOUR INSURANCE CARRIER MAY ULTIMATELY PAY.**

TERMS AND CONDITIONS

The parties agree to these Terms and Conditions in their entirety and understand and accept all of the provisions stated herein: I agree to comply with the office's financial policy. I understand that a consultation is complimentary, however a fee applies when exams or x-rays are performed. I understand interest of 1.5 percent per month / 18 percent per year will be charged on outstanding balances after 30 days. I understand that I am responsible for reasonable attorney fees, court costs, and / or collection costs in the event of nonpayment or is insufficient payment of my account, all without relief of the valuation and appraisement laws of the State of Indiana. For patients with insurance: I authorize the doctor to release to my insurance company any information obtained in the course of my examination or treatment. I understand that any treatment plan fees for dental care will be honored for a period of one month. We do NOT accept secondary insurance of any kind, however will provide you the forms to submit the claim yourself. I grant my permission to you or your assignee, to telephone me at home, on my cell or at work to discuss (or leave messages) concerning matters related to my financial obligations and/or treatment. I authorize the office to assess my account a $25.00 fee in the event that my dependent or I fail a scheduled appointment without 24-hour notification. By signing, I consent to the practice's use and disclosure of my, my parents, spouse, grandparent, child, (my dependent's, my parent's) protected health information to carry out treatment, payment activities, and healthcare operations. I also give consent for protected health information to be released/disclosed to additional persons such as a parent, spouse, guardian, grandparent, children, or caregivers.

DEPENDENT & MINOR PATIENTS

Because treatment cannot be provided without consent, ALL MINORS and DEPENDENTS must be accompanied by a parent or legal guardian to sign appropriate consent forms. Legal guardians must provide notarized Power of Health or Power of Attorney documentation.

Munster Distinctive Dentistry LLC

RELEASE OF DENTAL/INSURANCE INFORMATION:

[ ] I hereby authorize Munster Distinctive Dentistry, LLC to release information to the following:

_____, _____, on _____.
Printed name Relationship to patient Date

[ ] I authorize _____, _____, to consent to any dental treatment recommended
Printed name Relationship to patient
for my child/children.

I understand that this will remain in effect until terminated by _____ in writing.
Printed name of patient/legal guardian

ACKNOWLEDGEMENT OF POLICIES

_____ _____ Date: _____
Printed Patient Name Patient/Parent/Guardian Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____
Signature of patient, parent, or legal guardian

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Signature of Practice Associate: _____

Date: ____/____/____