10967 Allisonville Rd. Ste. 200
Fishers, IN. 46038
317-572-8626

Patient Information

First Name: ______________________ Last Name:____________________________ Middle Initial:_____

Address: ____ Apt./Lot #: ____________________

City: ______________________ State: _____ Zip Code: ______________

Home Phone: (______)-_______-_______ Cell Phone: (______)-_______-_______

Birth Date: _____________ Age: ____ Social Security #: _______________ Driver's Lic #: ________________

Can we contact you by text/email? ☐YES ☐NO Email: ____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Are any of your relatives patients at our office? ☐YES ☐NO If yes, please list names: ___________________________

***Responsible Party's Information (If someone other than the patient)**

Name: ___________________________ DOB:________ Relationship with the patient: _________________

Dental Insurance Information

Do you have Dental Insurance? ☐YES ☐NO Insurance Company's Name: ___________________________

Policy Holder's Name: ___________________ Birth Date: _________ Employer: _________________________

Address: ___________________________ Work Phone: ______________ Insurance Phone #:_____________

Policy Holder's SSN: __________________ Member ID#________________ Group#: ____________________

We Will File All Primary Insurance Claims As A Courtesy To Our Patients.
Understand that patient or guardian is responsible for any treatment not covered by the insurance company.

Who may we thank for referring you? Or How did you hear about us? ______________________________________

Please explain the main reason for consultation: ____

____ ____________

PATIENT OR RESPONSIBLE PARTY'S SIGNATURE **DATE**

DENTAL HISTORY

Patient's Name: ______________________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with dentistry that you will receive. Thank you for answering the following questions

Are you under the care of a physician now? ○Yes ○No if yes, please explain ___________________________________

Have you ever been hospitalized or had a major operation? ○Yes ○No if yes, please explain ___________________________________

Have you ever had a serious head or neck injury? ○ Yes ○No if yes, please explain ___________________________________

Are you taking any medications, pills, or drugs? ○Yes ○No if yes, please explain ___________________________________

Do you take, or have you taken, Phen- Fen or Redux? ○Yes ○No ____

Are you on a special diet? ○Yes ○No ____

Do you use tobacco? ○Yes ○No

Do you use a controlled substance? ○ Yes ○No

* **Women, Are you:** Pregnant/Trying to get pregnant? ○Yes ○No Nursing? ○Yes ○No Taking oral contraceptives? ○Yes ○No

Are you allergic to any of the following?

○Aspirin ○Penicillin ○Codeine ○Acrylic ○ Metal ○Latex ○ Local Anesthetics ○Other

If other, please explain: ____

Do you have, or have you had any of the following?

○AIDS/ HIV Positive	○Chest Pains	○Frequent Headaches	○Irregular Heartbeat	○Scarlet Fever
○Alzheimer's disease	○Cold Sores	○Genital Herpes	○Kidney Problems	○Shingles
○Anaphylaxis	○Congenital Heart Disorder	○Glaucoma	○Leukemia	○Sickle Cell
○Anemia	○Convulsions	○Hay Fever	○Liver Disease	○Sinus Trouble
○Angina	○Cortisone Medicine	○Heart Attack/Failure	○Low Blood Pressure	○Spine Bifida
○Arthritis/Gout	○Diabetes	○Heart Murmur	○Lung Disease	○Stomach Disease
○Artificial Heart Valve	○Drug Addiction	○Heart Pace Maker	○Mitral Valve Prolapse	○Stroke
○Artificial Joint	○Easily Winded	○Heart Trouble/Disease	○Pain in Jaw Joints	○Swelling of Limbs
○Asthma	○Emphysema	○Hemophilia	○Parathyroid Disease	○Thyroid Disease
○Blood Disease	○Epilepsy or Seizures	○Hepatitis A	○Psychiatric Care	○Tonsillitis
○Blood Transfusion	○Excessive Bleeding	○Hepatitis B or C	○Radiation Treatments	○Tuberculosis
○Breathing Problems	○Excessive Thirst	○Herpes	○Recent Weight Loss	○Tumors or Growth
○Bruise Easily	○Fainting Spells/Dizziness	○High Blood Pressure	○Renal Dialysis	○Ulcers
○Cancer	○Frequent Cough	○Hives or Rash	○Rheumatic Fever	○Venereal Disease
○Chemotherapy	○Frequent Diarrhea	○Hypoglycemia	○Rheumatism	○Yellow Jaundice

Have you ever had any serious illness not listed above? ○Yes ○No If yes, please explain: ______________________________________

***Last dental visit was ____________________________**
***Do you now have or have you had any of the following:**

☐Dental pain ☐Grinding Teeth ☐ Sensitive teeth ☐Food packing between teeth
☐Bleeding gums ☐ Pain in or near ears ☐Difficulty opening ☐Difficulty chewing

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____ ____________________

Patient/Responsible Party's Signature **Date**

Doctor's Signature: ____

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURES OF PERSONAL HEALTH INFORMATION

____ (print name) _______________________ Date

I ___________________________________, acknowledge that I have received a copy of this
(print name)

Office's NOTICE OF PRIVATE PRACTICES or that this office's NOTICE OF PRIVACY PRACTICE was made available to me to receive.

I, ____consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

my personal health information by your office for Treatment, Billing/Payment and Healthcare Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

FOR OFFICE USE ONLY

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

__Individual refused to sign

__Communications barrier prohibited obtaining the acknowledgement

__An emergency situation prevented us from obtaining acknowledgement

__Other (Please Specify)

FINANCIAL POLICY

Our office is committed to providing you with the highest quality dental care using only the best material and technology available. Our Clinical and Business Teams work closely together to provide a positive environment for visits to our office and assistance with financial requirements. A member of our Business Team will be delighted to discuss our options with you!

Payment: The full balance of treatment is due at the time services are rendered unless previous arrangements have been made. For your convenience we accept cash, check, debit card, CareCredit®, Master Card, Visa and Discover.

Financial Responsibility: The patient or responsible party receiving/authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other persons.

Statements: If you have a balance on your account, we will send you a statement in the mail. It will show your previous balance, any new charges, and any payments or credits applied to your account. We are on a 15-day billing cycle.

Past Due Accounts: Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date printed on the statement. A late fee may be charged on any account that is not paid within fifteen (15) days of the statement date. If necessary, accounts that are not paid within forty five (45) days may be referred to a collection agency. All reasonable expenses incurred in the collection process will be the account holder's responsibility.

Insurance: We are happy to file dental claims for our families who have dental insurance! In general, we will file claims to any company that will pay us directly and does not restrict coverage to a list of participating providers. Filing your insurance is not a guarantee of payment. Please understand that the patient, parent or guardian has the final responsibility for payment of any services rendered. Our doctor recommends treatment based on patient's needs, not on what insurance will pay. Therefore, we will do everything possible to maximize your benefits.
Your complete insurance information/card must be presented at the time services are provided and updated as necessary. Most benefits will be verified before your insurance company can be billed. In the event that your insurance has not paid your account within 60 days, the balance may be transferred to your account. We reserve the right to discontinue or refuse to file a claim.

Federal Employees: Insurance plans for federal employees make payments directly to the member. Payment in full will be collected on the day that treatment is provided.

Major Procedures: At the time of final delivery/cement of major services, account balances must be paid in full, no exceptions.

Required Payments: At treatment visits, we collect a percentage of the total cost of treatment, determined by an **ESTIMATION** of what your insurance will cover, plus any deductible required by your insurance. In the event of underpayment, we will send you a statement in the mail. In the event of overpayment on your part, you will be reimbursed by check in the mail.

Returned Checks: There will be a fee for any checks returned by the bank.

CareCredit®: A convenient alternative to credit cards, cash or checks. CareCredit® is a health care card that is exclusively utilized for dental and medical services. They offer flexible payment options that fit your timetable and budget. For additional information, contact us or visitwww.carecredit.com.
*All fees are subject as permitted under the laws of the State of Indiana.

Initials__________

APPOINTMENT POLICY

Patients accompanied by an adult: Children patients tend to do better in the dental office when they are not tired. Therefore, we encourage morning appointments, especially for pre-school or nervous children. For many children, just a simple filling at the end of a long day, when they are tired, can seem like a major ordeal. Please keep in mind, one of our goals is providing dentistry that is as pleasant as possible for your child. Also keep in mind that a dental appointment is an excused absence from school.

*When we schedule an appointment for you, that time is reserved solely for you. We do not double book and we take pride in the fact that because we value your time, as much as we hope you value ours, we make every effort to see you at the time scheduled. For this reason, it is very important that you arrive to the office at the time scheduled. If you are more than 20 minutes late, it may be necessary to reschedule your visit.

Cancelling or Rescheduling: If you are unable to keep a scheduled appointment, a 48-hour notice is required. We understand that unforeseen emergencies do occur, however, we reserve the right to charge your account a $40.00 fee for repeated last minute cancellations or broken appointments.

Effective Date: Once you have signed this policy, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Initials__________

I have read the above policies and understand my obligations with Teverbaugh Dental for my dental care.
I affirm that my signature represents my agreement to all of the terms mentioned above.

Patient/Parent/Guardian Print Name: ____

Patient/Parent/Guardian Signature: ____ **Date:** ___________