HEALTH HISTORY & REGISTRATION

ELLETTSVILLE DENTAL CENTER

PATIENT INFORMATION

Today's Date: _____

NAME: Last _____ First _____ Middle Initial____ Preferred Name _____

SS #_____ BIRTHDATE_____ AGE: _____ SEX M F

MARITAL STATUS_____ E-MAIL _____

Street Address _____ City _____ State _____ Zip _____

HOME # (___)_____ WORK # (___)_____ CELL # (___)_____

Employer: _____ Position: _____

If Patient is a Minor, give Parent's or Guardian's Name: _____

Whom May We Thank for Referring You to our Office? ☐ Friend ☐ Relative ☐ Referring Physician Name: _____

RESPONSIBLE PARTY INFORMATION (if other than patient)

NAME: Last _____ First _____ Middle Initial ____ MARITAL STATUS_____

SS # _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

Street Address _____ City _____ State _____ Zip _____

HOME # (___)_____ WORK # (___)_____ CELL # (___)_____

EMPLOYER _____ OCCUPATION _____ # YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME: Last_____ First_____

BIRTHDATE _____ SS # _____

OCCUPATION _____

EMPLOYER _____

YEARS EMPLOYED_____ WORK PHONE (___)_____

EMERGENCY CONTACT INFORMATION:

NAME: _____

PHONE _____

RELATIONSHIP _____

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Name:_____ Birthdate _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's SS/ID#_____ Group# _____

SECONDARY DENTAL INSURANCE INFORMATION

Insured's Name:_____ Birthdate _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's SS/ID#_____ Group# _____

- Continue on other side -

* PATIENT MEDICAL HISTORY *

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐

For What?

Physician's name:

What MEDICATIONS or SUPPLEMENTS (including over-the-counter) do you take?

Women: Do you Take BIRTH CONTROL PILLS?_____
PREGNANT? ☐ Yes ☐ No, Due Date _____

Do you SMOKE ? _____ Amount per day? _____

Do you VAPE? _____

Do you use SMOKELESS TOBACCO products? _____

If yes, for how long & what amount per day? _____

(CIRCLE) ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO:

Aspirin	Erythromycin	Local Anesthetic	Penicillin
Codeine	Latex Allergy	Nitrous Oxide (Gas)	Sulfa

Are you aware of being Allergic to any Other medications or substances? **YES** **NO**

If yes, please list:_____

(CIRCLE) ANY OF THE FOLLOWING YOU HAVE HAD, OR PRESENTLY HAVE:

Acid Reflux	Diabetes	Kidney trouble
AIDS/HIV Positive	Drug Addiction	Liver Disease
Alcoholism	Emphysema	Mitral Valve Prolapse
Allergies or Hives	Epilepsy or Seizures	Persistant Cough
Angina Pectoris	Fever Blisters	Radiation treatment
Anxiety	Glaucoma	Rheumatic Fever
Arthritis	Heart Attack	Stroke
Artificial Heart Valve	Heart Disease	Sinus trouble
Artificial Joints (hip, knee)	Heart Murmur	Sleep Apnea
Asthma	Heart Pacemaker	Snoring
Chemotherapy (cancer, leukemia)	Heart Surgery	Thyroid Disease
	Hemophilia (bleeding problems)	Tuberculosis (TB)
Congenital Heart Lesions	Hepatitis	Ulcers
Cough that produces Blood	Herpes	Venereal Disease (syphilis, gonorrhea, etc)
Depression	High Blood Pressure	

Is there any other Medical or Dental information that you feel we should be aware of?

_____

* PATIENT DENTAL HISTORY *

HOW LONG since you have seen a Dentist?_____

Is your present dental health ☐ GOOD ☐ FAIR ☐ POOR

Are you having PROBLEMS now?_____

If yes please explain: _____

	YES	NO
Do you REGULARLY use DENTAL FLOSS or a WATER PIK?	☐	☐
Are you AFRAID or NERVOUS about dental treatment?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle any)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, NECK, or JAW PAINS?	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Have you ever used a CPAP machine?	☐	☐
Do you you feel SLEEPY during the day?	☐	☐
Do you SNORE?	☐	☐
Have you ever been told you STOP BREATHING while sleeping?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐

How do you feel about your teeth? _____

* FINANCIAL POLICIES *

1) FINANCE CHARGE - I agree to pay up to 1 1/2% per month (**18%** Annual Percentage Rate) on any balance over 60 Days old.

2) BILLING CHARGE - I agree to pay up to **$5** per month for billing costs, if any balance must be billed over 60 Days.

3) COLLECTION COSTS - I agree to pay any **attorney fees, court costs,** and a **35%** Collection Fee if collection by a third party is necessary.

4) BAD CHECK CHARGE - I understand that a **$20** charge will be added to my balance if any check is returned for insufficient funds.

5) RESPONSIBLE PARTY - The parent/guardian who presents a **minor child** for treatment is responsible for payment of the account, regardless of any court orders stating otherwise, unless **written** permission to bill another party is presented to our office at the time of service.

The information I have given today is correct to the best of my knowledge. It is my responsibility to **inform** this office of any changes in medical status. I authorize the dental staff to **perform any necessary dental services** with my informed consent that may be needed during diagnoses and treatment. I authorize **release of any information** including the diagnosis and records of any treatment rendered to me or my child to **insurance companies or health practitioners.** I authorize and request my insurance company to **pay directly to the dentist** benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to pay any amount not covered. I understand the **Financial Policies** and agree to be **responsible for payment** of all services rendered to me or my dependents.

SIGNATURE OF PATIENT or RESPONSIBLE PARTY:

Ⓧ _____ DATE:_____

Ellettsville Dental Center

5915 West Highway 46 · P.O. Box 518 · Ellettsville, IN 47429
Telephone: (812) 876-7330

HIPAA INFORMATION: I acknowledge that I have received and read a copy of the HIPAA Notice of Privacy Practices. This notice describes how my Protected Health Information about me may be used and disclosed and how I can access this information. The Notice of Privacy Practices is based on current federal law and subject to change based on changes in federal law and subject to change based on changes in federal law or subsequent interpretative guidance.

Initial _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION: I authorize my provider to release information from my health information to my insurance carrier(s) for processing of claims for my benefit. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my provider, on my behalf.

Initial _____

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION: I request that the following be followed for the disclosure of my Protected Health Information (which includes your name, diagnosis(es), test results, dates of services).

Please check all that apply

☐ You may disclose information to my family members or non-family members (please list name, phone number, and relationship)

Name	Phone Number	Relationship

☐ May leave Protected Health Information on my answering machine/voicemail
Phone Number: _____

☐ Authorize postcards via US Mail (example: appointment reminders)

☐ Text appointment confirmation: _____

☐ E-mail correspondence: _____

☐ Other: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____