Prosthodontics of Central Indiana
Practice Limited To Prosthodontics
PENNWOOD OFFICE PARK, BUILDING 1
11405 N. Pennsylvania St., Suite 110, Carmel, IN 46032
(317)574-0866

Patient Name: ______________________ Date of Birth: ______________
Address: ______________________ City: ______________
State: __________ Zip: __________ Phone#: H __________ Wk __________
Cell / Text __________ E-mail__________ SS #: __________Marital Status: M S W D

Employer: ______________________Phone #: ______________
Address: ______________ City: ______________ State: ______ Zip: ______

Spouse Name (Parent or Guardian if Patient is a minor): ______________
Social Security #: ______________ Date of Birth: ______________
Employer: ______________ Address: ______________
City: ______________ State: ______ Zip: ______ Phone #: ______

In Case of Emergency, nearest relative not living with you:
Name: ______________________ Phone #: ______________

Person responsible for Account (if other than Patient)
Name: ______________________ Relation to Patient: ______________
Address: ______________________ City: ______________
State: __________ Zip: __________ Phone #: H__________ Wk __________ Cell __________
Social Security Number: ______________ Date of Birth: ______________
Employer: ______________ Address: ______________
City: ______________ State: ______ Zip: ______ Phone #: ______

Financial Responsibility Agreement
In consideration of treatment rendered the above named Patient, I accept full financial responsibility. Insurance forms will be completed as a convenience to the Patient; however, payment to the doctor is expected at the time services are rendered, unless other arrangements are made in advance. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection cost, interest of 21% APR, court costs and reasonable attorney fees.
Signature ____
(Relation to Patient if Minor) Date

Insurance Information (Please present your insurance card to the receptionist)
If you wish for our office to process your insurance claim for you, please sign the insurance authorization below:
Signature ____
Date

Consent For Use And Disclosure Of Health Information
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

(You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve *the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.)*
Signature/Personal Representative's Name ____
Date

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation.
Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.
Signature/Personal Representative's Name ____
Date