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: _____ Pharmacy:_____

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 #: _____

*** Please see reverse side ***

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

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

Consent to Treatment

I consent to receive dental examinations, x-rays, cleanings, preventive care, and any other dental treatment deemed necessary or advisable by the dentist and clinical staff. I understand that I will be informed of proposed treatment options, risks, benefits, and alternatives, and I will have the opportunity to ask questions before agreeing to any procedure. I authorize the dental team to provide such care, and I acknowledge that no guarantees have been made regarding treatment outcomes.

Signature/Personal Representative's Name Date

Primary Reason for this dental appointment:

☐ Exam ☐ Emergency | Consultation

Dental History **Please Circle**

Do you have a specific dental problem? Describe: _____	Yes	No
Do you have dental exams on a routine basis? Last Visit: _____	Yes	No
Do you think you have active decay or gum disease?	Yes	No
Do you brush and floss on a routine basis?	Yes	No
Do your gums ever bleed?	Yes	No
Do you like your smile?	Yes	No
Does food catch between your teeth?	Yes	No
Do you have any loose teeth?	Yes	No
Do you want to kee your remaining teeth?	Yes	No
Do you have clicking, popping or discomfort in your jaw joint?	Yes	No
Do you brux or grind?	Yes	No
Have your past dental expirences been positive?	Yes	No
Do you smoke or use chewing tobacco?	Yes	No
Do you have sores or growths in your mouth?	Yes	No

Describe:

Name of previous dentist(optional):

Date of last full mouth xrays:

Are you under a physicans care?	Yes	No

Who? _____ Phone: _____

Why?

Have you ever been hospitalized or had a major operation?	Yes	No

Describe:

Have you ever had a serious injury to your head or neck?	Yes	No

Describe:

Are you taking any medications, asprin, vitamins, herbals, pills or drugs?	Yes	No

List:

Are you on a special diet?	Yes	No

Describe:

Are you allergic to any medications or substances?	Yes	No

☐ Asprin ☐ Penicillin ☐ Metal | ☐ Other: _____

☐ Codine ☐ Acrylic ☐ Latex | Milk _____

For Women:

☐ Pregnant or trying to concieve? | Taking Oral Contraceptives?

☐ Nursing? What? _____

*** Please see revere side as well. ***

Do you now have, or have you ever had any of the following?
Do you take any of these medicines?
Please circle appropriate responses.
If yes to any of the starred conditions, please call prior to your appointent, premedication or changes in medication may be required.

Heart Disease/Surgery*	Yes	No	Chemotherapy	Yes	No
Heart Murmur/Defect*	Yes	No	Osteoporosis	Yes	No
Irregular Heart Beat	Yes	No	Bisphosphonates	Yes	No
Angina/Chest Pain	Yes	No	Osteonecrosis of Jaw	Yes	No
Heart Attack/Failure	Yes	No	Aredia I.V. Reclast I.V.	Yes	No
Congenital Heart Disorder*	Yes	No	Zometa I.V.	Yes	No
Mitral Valve Prolapse*	Yes	No	Fosamax, Actonel, Boniva	Yes	No
Scarlet Fever	Yes	No	Stomach/Intestinal Disease	Yes	No
Rheumatic Fever*	Yes	No	Ulcers	Yes	No
Artificial Heart Valve	Yes	No	Recent Weight Loss	Yes	No
Heart Pace Maker	Yes	No	Frequent Diarrhea	Yes	No
Pulmonary Shunt*	Yes	No	Diabetes	Yes	No
High Blood Pressure	Yes	No	Excessive Thirst	Yes	No
Low Blood Pressure	Yes	No	Hypoglycemia	Yes	No
Bacterial Endocarditis*	Yes	No	Liver Disease	Yes	No
Unexplained Fever	Yes	No	Hepatitis A (Infectious)	Yes	No
Bruise Easliy/Blood Disease	Yes	No	Hepetitis B or C	Yes	No
Anemia	Yes	No	Protease Inhibitor	Yes	No
Coronary Stent	Yes	No	Night Sweats	Yes	No
Excessive Bleeding	Yes	No	Yellow Juandice	Yes	No
Sickle Cell Disease	Yes	No	Kidney Problems	Yes	No
eophilia	Yes	No	Renal Dialysis	Yes	No
Methemogloineia	Yes	No	Thyroid Disease	Yes	No
Leukemia	Yes	No	Parathyroid Disease	Yes	No
Recent blood transfusion	Yes	No	Artritis/Gout	Yes	No
Swelling of Limbs	Yes	No	Rheumatism	Yes	No
Lung Disease	Yes	No	Pain in Jaw Joints	Yes	No
Breating Problems	Yes	No	Cortisone Medicine	Yes	No
Shortness of Breat	Yes	No	Artificial Joint *	Yes	No
Frequent Cough	Yes	No	Sexually Transmitted Disease	Yes	No
Hay Fever	Yes	No	AIDS	Yes	No
Sinus Trouble	Yes	No	HIV Positive	Yes	No
Asthma	Yes	No	Genital Herpes	Yes	No
Bloody Sputum	Yes	No	Drug Addiction/Alcholism	Yes	No
Emphysema	Yes	No	Tattoos/Body Piercing	Yes	No
Tuberculosis	Yes	No	Smoking	Yes	No
Cancer	Yes	No	Cold Sores	Yes	No
Radiation	Yes	No	Fever Blisters	Yes	No

Herpes	Yes	No	Psychiatric Care	Yes	No
Stroke	Yes	No	Alzheimer's Disease	Yes	No
Convulsions	Yes	No	Allergies(to Medicines)	Yes	No
Epilepsy or Seizures	Yes	No	Seasonal Allergies	Yes	No
Fainting or Dizziness	Yes	No	Hives or Rash	Yes	No
Glaucoma	Yes	No	Require Premedication	Yes	No
Tumors or Growths	Yes	No	Fen-Phen	Yes	No
Nervousness	Yes	No	Cochlear Implants	Yes	No

Do you wish to speak privately with the doctor about any problem? Yes No

Have you ever had any other serious illness not circled above? Explain: _____

To the best of my knowledge all preceding answers are correct. If I have any canges in my health status or if my medicines change, I shall inform the doctor and staff at the next appointment without fail.

X _____

Patient Signature(Parent or Guardian Date

Prosthodontics of Central Indiana
11405 Pennsylvania Street, Suite #110, Carmel, IN 46032

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, _____, Date of Birth _____, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results, date of services.

- Sensitive Protected Health Information (HIV – related information)
- You may disclose information to my family members and/or non-family members

Please list the name, phone number, and relationship:

NAME	PHONE NUMBER	RELATIONSHIP

- You may leave Protected Health Information on my answering machine/voicemail:
  Phone Number: _____
- You may leave me a text message:
  Text Phone Number: _____
- You may email me (unencrypted) for appointments:
  Email Address: _____
- Other: _____

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

Print Name: _____

Signature: _____

(Patient's Signature (or Guardian, if Minor))

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
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please specify): _____