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.

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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