angela b. smith, d.d.s.
family dental care
101 Charles Street
Loogootee, IN 47553
812.295.4000

PATIENT INFORMATION

PATIENT NAME: ____ **AGE:** _________ **TODAY'S DATE:** __________________

PATIENT ADDRESS: ____
Number Street City Zip

HOME PHONE: ____________________ **WORK PHONE:** ______________________ **CELL PHONE:** __________________

EMPLOYER: _____________________ **OCCUPATION:** ________________ **E-MAIL:** ______________________________

EMPLOYER ADDRESS: ____

SOC. SEC. #: ________________________ **BIRTH DATE:** _______________ **SEX:** _________ **MARITAL STATUS:** _______

FAMILY PHYSICIAN: ____________________________________ **PHONE:** _______________________________________

WHOM MAY WE THANK FOR REFERRING YOU? ____

SPOUSE'S NAME: ___________________________________ **RELATIONSHIP TO RESPONSIBLE PARTY:** _____________

RESPONSIBLE PARTY

(Individual Responsible for Payment)

NAME: ____ **PHONE:** ____

ADDRESS: ____
Number Street City Zip

SOC. SEC. #: ___________________________ **BIRTHDATE:** _______________________ **SEX:** _____________________

EMPLOYER: _______________________________________ **OCCUPATION:** ____________________________________

ADDRESS: ____ **WORK PHONE:** ____________________________________

SOC. SEC. #: ___________________________ **BIRTH DATE:** _______________________ **SEX:** _____________________

INSURANCE

PRIMARY INS CO: ____________________________ **POLICY HOLDER:** _______________________________________

POLICY HOLDER SOC. SEC. #: ____________________ **DOB:** _______________ **EMPLOYER:** _____________________

ADDRESS: ____
Number Street City Zip

SECONDARY INS. CO: ______________________________ **POLICY HOLDER:** ___________________________________

POLICY HOLDER SOC. SEC. # _______________________ **DOB:** ___________________ **EMPLOYER:** ________________

ADDRESS: ____
Number Street City Zip

MEDICAL HISTORY

WHAT IS YOUR DENTAL PROBLEM? ____

Describe your present health: ___Good ___Fair ___ Poor Are you having pain or discomfort at this time? _
Are you under a physician's care 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: ______________________
Do you take, or have you taken Phen- Fen or Redux? ___Yes ___No ______________________________
Have you ever taken Fosamax, Boniva, Actonel or any other
medications containing bisphosphonates? ____Yes____No______________________________
Are you on a special diet? ___Yes ___No ______________________________
Do you use tobacco? ___Yes ___No How much? ______________________________
Do you use a controlled substance? ___Yes ___No
Have you ever had complications or illness following dental treatment? If yes, please explain: ____________________
When was your last dental visit? ____________________ Reason? ______________________________
Are you nervous or concerned about having dental treatment? ______________________________

Women:

Pregnant/Trying to get pregnant? ___Yes ___No Taking oral contraceptives? ___Yes ___No Nursing? ___Yes ___No

Are you allergic to any of the following?
___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetic
___Other If other, please explain: ______________________________

Disabled: ___Yes ___No Circle all that apply: Medically Mentally (psychologically or medical) Physically

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

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

HAVE YOU EVER HAD ANY SERIOUS ILLNESS OR HEALTH PROBLEM NOT LISTED ABOVE? ____________________
If yes, please explain: ______________________________

LIST ANY MEDICATIONS YOU ARE PRESENTLY TAKING: ______________________________
____

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? If not, why? ______________________________

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the Doctor or Hygienist at the next appointment without fail.
Signed: ______________________________ Date: ____________________
Signature of Patient or Parent Requesting Care

I hereby consent to any x-rays or diagnostic tools Dr. Angela Smith deems necessary to diagnose any possible dental conditions.
Signed: ______________________________ Date: ____________________
Signature of Patient or Parent Requesting Care

Family Dental Care, P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________________ E-mail: ______________________________

Social Security Number: ______________________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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.

Notice of Privacy Practices: 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kara Denise Bowling

Telephone: (812) 295-4000 Fax: (812) 295-4626

E-mail: ______________________________

Address: 101 Charles Street, Loogootee, IN 47553

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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, ______________________________, have been made aware I can receive a copy of this office's Notice of Privacy Practices upon request.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ______________________________ Date: ______________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

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: ______________________________ Date: ______________________________

FINANCIAL POLICY

INSURANCE POLICY:

As a courtesy, Dr. Angela Smith will submit claims to all insurance carriers. Our knowledgeable staff will help you recover the most from your insurance benefits. To do this, we must have the most current insurance card(s) and other necessary personal information at the time of service. Submitting claims to an insurance company on behalf of the patient does not imply that we are "in-network" or "contracted" with that insurance company. Dr. Angela Smith is a preferred provider with Blue Cross/Blue Shield, Delta Dental, HRI, United Concordia, MetLife, Principal, and Medicaid. However, it is the patient's responsibility to know if Dr. Smith is considered "in-network" or a "contracted" provider within their insurance carrier network.

Although our office makes every attempt to know about the general policies for a number of insurance companies, it is impossible for us to know about each individual plan. It is therefore your responsibility to know your policy and the rules upheld by your dental insurance company including covered and non-covered services.

We allow a maximum of 90 days for the receipt of insurance payment. However, if payment is not received in this time, the patient will become responsible for payment of the account. Please understand that insurance coverage is a relationship between the insurance company and the insured (the patient).

Your deductible and the portion of care we estimate your insurance will not cover are due at time of the appointment. Any balance due after the insurance claim has been paid will be billed to the patient and is due within 30 days. Any resulting overpayment will be refunded to the patient in a timely manner.

PAYMENT OPTIONS:

For your convenience, we accept cash, check, and credit cards (Visa and MasterCard). Individual financial arrangements can be made through our in-office financing partnership with Care Credit. Care Credit is here to help you pay for treatment and procedures your insurance doesn't cover. There are "no interest" financing or low monthly payment options with interest. If you would like to inquire about Care Credit, please don't hesitate to ask our knowledgeable staff.

APPOINTMENTS:

We respect your time and do our very best to honor our appointment schedule. Just as we strive to adhere to our appointment schedule, we ask our patients to do the same. If you need to reschedule an appointment, please call us at your earliest opportunity. We do require a 24 hour notice for cancellations. We ask for this advance so that we can offer this appointment to another patient. In consideration of other patients, we may need to reschedule your appointment if you are more than 10 minutes late. We reserve the right to charge for failed appointments (minimum $30). An appointment is considered "failed" if it is canceled with less than a 24 hour notice. Dr. Smith reserves the right to refuse future appointments.

PHOTO RELEASE:

I hereby consent to release for possible publication, my photo and images taken by any employee of Angela B Smith, D.D.S. We will make every effort to hide the identity of the patient and focus primarily on the treatment being performed. I agree to allow the publication of any photos or images of me on any social media site such as Facebook, Instagram, and Twitter, etc.

COLLECTIONS:

Any balance that remains unpaid for more than 90 days will be assessed a finance charge of 1 ½% per month (18% annually). Items pending insurance will not be charged interest. If collections procedures are required, the patient is responsible for all collection fees. A $25 fee will be charged for all returned checks.

I have read the above financial policy and agree to the terms outlined. I hereby authorize payment to Dr. Angela Smith of the group insurance benefits otherwise payable to me. Additionally, I authorize the release of any information relating to dental claims submitted by Dr. Smith to my insurance company. I understand that I am responsible for all fees for dental treatment regardless of payment by my insurance company, and I fully understand that an appointment canceled with less than 24 hours notice is subject to a failed appointment charge as noted.

SIGNATURE: ____ **DATE:** ____________________