**St John Smiles**
**9486 Wicker Ave, St. John, IN 46373**

## DEMOGRAPHICS

**First Name: _____ Last Name: _____**
**What name does the patient prefer to go by?: _____**
**Circle One: Male Female Birth Date: ____ / ____ / _____**
**Email Address: _____**
**SSN: _____**
***Complete any numbers below that we may contact you:***
**Mobile Phone Number: _____**
**Work Phone Number: _____ Home Phone Number: _____**
**Address Line 1: _____**
**Address Line 2: _____**
**City: _____ State: _____ Postal Code: _____**
**Who has legal custody of the patient?: _____**
**Primary Contact Details - who should we contact for scheduling?**
**Primary Contact Name: _____**
**Relationship to Patient: _____ Phone Number: _____**
**Address Line 1: _____**
**Address Line 2: _____**
**City: _____ State: _____ Postal Code: _____**
**How did you hear about us?: ☐Google ☐Facebook ☐Drive By**
**☐Patient: _____ ☐Other _____**

## RESPONSIBLE PARTY / GUARANTOR INFORMATION

**Is the patient also the guarantor? ☐YES ☐NO**
***If yes, check the box and skip this section. If no, complete the following:**

**Guarantor First and Last Name: _____**
**Relationship to Patient (Circle): Child Spouse Other**
**Phone Number: _____**
**Address Line 1: _____**
**Address Line 2: _____**
**City: _____ State: _____ Postal Code: _____**

## EMPLOYMENT DETAILS

**Occupation: _____ How long?: _____**
**Employer Name: _____**
**Please list any contact names to whom the practice can release PHI information (HIPAA)**
**First and Last Name: _____ Phone Number: _____**
**First and Last Name: _____ Phone Number: _____**

## EMERGENCY CONTACT

**First Name: _____ Last Name: _____**
**Phone Number: _____**
**Who is filling out the form today?**
**First Name: _____ Last Name: _____**
**Phone Number: _____ Signature: _____**

# DENTAL INSURANCE INFORMATION

## PRIMARY DENTAL INSURANCE

**Do you have dental insurance? ☐ YES ☐ NO *If no, skip the rest of this form**
**Name of Insured: _____**
**Insured's Birth Date: ____ / ____ / _____**
**Insured's Address Line 1: _____**
**Address Line 2: _____**
**City: _____ State: _____ Postal Code: _____**
**Patient's Relationship to Insured: Spouse Child Other**
**Insured's Employer Name: _____**
**Employer's Address Line 1: _____**
**Employer's Address Line 2: _____**
**City: _____ State: _____ Postal Code: _____**

### Insurance Carrier Information

**Carrier Name: _____**
**Plan Name: _____ ID #: _____**
**Group #: _____**
**Insurance Company Phone Number: _____**
**Insurance's Address Line 1: _____**
**Insurance's Address Line 2: _____**
**Insurance's City: _____ Insurance's State: _____**
**Insurance's Postal Code: _____**

## SECONDARY DENTAL INSURANCE

**Do you have Secondary Insurance? ☐ YES ☐ NO**
**Name of Insured: _____**
**Insured's Birth Date: ____ / ____ / _____**
**Insured's Address Line 1: _____**
**Insured's Address Line 2: _____**
**Insured's City: _____ Insured's State: _____**
**Insured's Postal Code: _____**
**Patient's Relationship to Insured: Spouse Child Other**
**Insured's Employer (Secondary) Employer Name: _____**
**Employer's Address Line 1: _____**
**Address Line 2: _____**
**City: _____ State: _____ Postal Code: _____**

### Secondary Insurance Carrier

**Carrier Name: _____**
**Plan Name: _____ ID #: _____**
**Group #: _____**
**Insurance Company Phone Number: _____**
**Insurance's Address Line 1: _____**
**Address Line 2: _____**
**City: _____ Insurance's State: _____ Postal Code: _____**

**Signature: _____ Date: ____ / ____ / _____**

***Please note, due to Insurance carrier limitations and claims processing times, we will base insurance estimates off of your primary insurance. Once the secondary insurance claim is closed, we will determine if a refund is owed and process once the claim has been resolved.**

# FINANCIAL POLICY

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE BY TIME OF SERVICE. For more extensive cases, full payment is due a week ahead of the scheduled procedure. Parents not accompanying their child to an appointment must make prior arrangements for payment.

CHILDREN UNDER 18 MUST be ACCOMPANIED BY PARENT OR ADULT OVER 21 WITH WRITTEN CONSENT FROM PARENT. Parents accompanying their children are financially responsible for payment. Patients with insurance: We will provide an ESTIMATE of Insurance coverage as a courtesy based on information we receive from insurance. The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of service. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Other times where the balance may become your responsibility is due to the following:
-Treatment goes over maximum benefits.
-Insurance benefits have been utilized elsewhere.
-Patient is not eligible for insurance when services are rendered.
-Patient prevents or delays the payment by not complying with requests for insurance forms or signatures.
-Patient did not complete treatment and it resulted in nonpayment by the insurance company. -Lab costs are incurred due to missing appointments.
-Lab modifications or customizations not covered by insurance
-Insurance check is mailed to the patient and is not forwarded to practice.

Accepted Forms of Payment: To protect our employees and patients, we are a cashless practice. We accept Debit Cards, Visa, Mastercard, Discover, American Express, Care Credit, Apple Pay, and Google Pay. We also offer convenient financing options such as Sunbit, Proceed Financing and Lending Point. If you would like to learn more about Sunbit, Care Credit or Proceed Finance, any of our team members would be happy to give you more information. Please note, we do not accept personal checks. There is a $40.00 processing fee for non-sufficient funds. Past due balances may be subject to convenience and late fees.

Additional Fees/ Disclosures: A fee equivalent to 20% of the scheduled treatment may be added to your account should the patient fail to give less than 48 hours notification for cancellation or rescheduling. This amount may be higher for extensive cases such as implants and cosmetic cases Records can be viewed at any time. There is a nominal charge for release or copies of records.

When scheduling an appointment for treatment, a reservation fee will be required and applied towards any services scheduled. The reservation fee is a minimum of 50% of the patient portion or $75 per scheduled hour of treatment, whichever is greater.

Because instruments, chairs and personnel are reserved exclusively for your appointment, there will be a CHARGE PER PATIENT FOR MISSED/CANCELED/RESCHEDULED APPOINTMENTS WITH LESS THAN A 48 HOUR NOTICE IN ADVANCE of 20% of the total fee or $75 per hour scheduled, whichever is greater.

The fee for extensive cases is higher. I understand that my dentist and staff will estimate insurance as close as possible. I understand that I am responsible for the payment of the account and providing correct insurance information. I understand that if insurance is not applicable when dental services are rendered; my full payment is due at the time of service. I understand the above information and agree with its contents, and this will serve as my signature.

Signature: _____ Printed Name: _____

Date: _____

# MEDICAL HISTORY



| | | | | | |
|---|---|---|---|---|---|
| **Allergy - Aspirin** | **Yes** | ☐ | | **No** | ☐ |
| **Allergy - Codeine** | **Yes** | ☐ | | **No** | ☐ |
| **Allergy - Latex** | **Yes** | ☐ | | **No** | ☐ |
| **Allergy - Local Anesthetic** | **Yes** | ☐ | | **No** | ☐ |
| **Allergy - Penicillin** | **Yes** | ☐ | | **No** | ☐ |
| **Allergy - Sulfa** | **Yes** | ☐ | | **No** | ☐ |
| **List any other allergies:** | | | | | |
| **Abnormal (High/Low) Blood Pressure** | **Yes** | ☐ | | **No** | ☐ |
| **AIDS/HIV** | **Yes** | ☐ | | **No** | ☐ |
| **Anemia / Bleeding Problems** | **Yes** | ☐ | | **No** | ☐ |
| **Artificial Heart Valves** | **Yes** | ☐ | | **No** | ☐ |
| **Blood Disease** | **Yes** | ☐ | | **No** | ☐ |
| **Congenital Heart Lesions** | **Yes** | ☐ | | **No** | ☐ |
| **Heart Problems** | **Yes** | ☐ | | **No** | ☐ |
| **Pacemaker** | **Yes** | ☐ | | **No** | ☐ |
| **Arthritis / Rheumatism / Gout** | **Yes** | ☐ | | **No** | ☐ |
| **Artificial Joints / Bones** | **Yes** | ☐ | | **No** | ☐ |
| **Asthma** | **Yes** | ☐ | | **No** | ☐ |
| **Cancer** | **Yes** | ☐ | | **No** | ☐ |
| **Chemotherapy** | **Yes** | ☐ | | **No** | ☐ |
| **Diabetes** | **Yes** | ☐ | | **No** | ☐ |
| **Emphysema** | **Yes** | ☐ | | **No** | ☐ |
| **Glaucoma** | **Yes** | ☐ | | **No** | ☐ |
| **Radiation Treatment (Xray/Cobalt)** | **Yes** | ☐ | | **No** | ☐ |
| **Shortness of Breath (Breathing Problems)** | **Yes** | ☐ | | **No** | ☐ |
| **Sinus Trouble** | **Yes** | ☐ | | **No** | ☐ |
| **Stroke** | **Yes** | ☐ | | **No** | ☐ |
| **Thyroid Problems** | **Yes** | ☐ | | **No** | ☐ |
| **Tuberculosis** | **Yes** | ☐ | | **No** | ☐ |
| **Tumor / growth on head / neck** | **Yes** | ☐ | | **No** | ☐ |
| **Ulcer** | **Yes** | ☐ | | **No** | ☐ |
| **Epilepsy** | **Yes** | ☐ | | **No** | ☐ |
| **Fainting / Dizziness** | **Yes** | ☐ | | **No** | ☐ |
| **Headaches (Frequent)** | **Yes** | ☐ | | **No** | ☐ |
| **Hepatitis** | **Yes** | ☐ | | **No** | ☐ |
| **Herpes** | **Yes** | ☐ | | **No** | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| **Kidney Disease** | **Yes** | ☐ | | **No** | ☐ |
| **Liver Disease** | **Yes** | ☐ | | **No** | ☐ |
| **Nervous Problems** | **Yes** | ☐ | | **No** | ☐ |
| **Psychiatric Care** | **Yes** | ☐ | | **No** | ☐ |
| **List any other medical issues you have:** | | | | | |
| **List any serious Illnesses / surgeries / hospitalizations:** | **Yes** | ☐ | | **No** | ☐ |
| **Are you taking any medications?** | **Yes** | ☐ | | **No** | ☐ |
| **List medications you are taking:** | | | | | |
| **Do you smoke?** | **Yes** | ☐ | | **No** | ☐ |
| **Do you drink alcohol?** | **Yes** | ☐ | | **No** | ☐ |
| **High Sugar intake?** | **Yes** | ☐ | | **No** | ☐ |
| **Pregnant** | **Yes** | ☐ | | **No** | ☐ |
| **Nursing** | **Yes** | ☐ | | **No** | ☐ |
| **Is the patient under the care of a physician?** | **Yes** | ☐ | | **No** | ☐ |
| **Physician Name:** | | | | | |
| **Physician Phone Number:** | | | | | |
| **Has the patient ever been hospitalized?** | **Yes** | ☐ | | **No** | ☐ |
| **Please state the reason for hospitalization:** | | | | | |
| **Is the patient physically, mentally or emotionally impaired?** | **Yes** | ☐ | | **No** | ☐ |
| **Describe the patient's current physical health:** | | | | | |

**Signature:** _____ **Date:** _____

# DENTAL HISTORY

| | | | | | |
|---|---|---|---|---|---|
| **Is the patient a minor?** | **Yes** | ☐ | | **No** | ☐ |
| **Is this your child's first dentist visit?** | **Yes** | ☐ | | **No** | ☐ |

**Please provide the following provider details:**

| |
|---|
| **Provider Name:** |
| **Provider Phone Number:** |

**Does your child have any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| **Cavities / Decay** | **Yes** | ☐ | | **No** | ☐ |
| **Lip Sucking / Biting** | **Yes** | ☐ | | **No** | ☐ |
| **Speech Problems** | **Yes** | ☐ | | **No** | ☐ |
| **Nail Biting** | **Yes** | ☐ | | **No** | ☐ |
| **Pacifier / Thumb / Finger Sucking** | **Yes** | ☐ | | **No** | ☐ |
| **Mouth Breathing** | **Yes** | ☐ | | **No** | ☐ |
| **Tongue Thrust** | **Yes** | ☐ | | **No** | ☐ |
| **Nursing / Bottle Habits** | **Yes** | ☐ | | **No** | ☐ |
| **Jaw Problems** | **Yes** | ☐ | | **No** | ☐ |
| **Grinding Teeth** | **Yes** | ☐ | | **No** | ☐ |
| **Has the patient ever had orthodontic treatment (Braces)?** | **Yes** | ☐ | | **No** | ☐ |
| **Has the patient ever had any pain or tenderness in their jaw joint (TMJ/TMD)?** | **Yes** | ☐ | | **No** | ☐ |
| **Reason for visit:** | | | | | |
| **Date of last dental visit:** | | | | | |
| **Date of last dental X-rays:** | | | | | |
| **How often do you floss?** | | | | | |
| **How often do you brush?** | | | | | |
| **Bad Breath** | **Yes** | ☐ | | **No** | ☐ |
| **Bleeding, Red, Swollen Gums** | **Yes** | ☐ | | **No** | ☐ |
| **Broken/Loose teeth or fillings** | **Yes** | ☐ | | **No** | ☐ |
| **Clicking or popping jaw** | **Yes** | ☐ | | **No** | ☐ |
| **Grinding teeth** | **Yes** | ☐ | | **No** | ☐ |
| **Pain around ear/side of face** | **Yes** | ☐ | | **No** | ☐ |
| **Sores/Blisters in mouth** | **Yes** | ☐ | | **No** | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| **List any other dental concerns/pain:** | | | | | |
| **What did you like the most about your previous dental office?** | | | | | |
| **What did you like the least about your previous dental office?** | | | | | |
| **Are you interested in whitening your smile?** | **Yes** | ☐ | | **No** | ☐ |
| **Are you happy with your smile?**<br>**If not, what would you change?** | **Yes** | ☐ | | **No** | ☐ |

**Signature: _____ Date: _____**

## NOTICE: X-RAYS AND INSURANCE COVERAGE

**We will recommend that certain x-rays be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.**

**I understand the above information and agree with its contents, and this will serve as my signature.**

**Signature: _____ Date:_____**

# EMAIL AND TEXT MESSAGE CONSENT

**Using electronic transmission of patient information by email and/or text messaging has a number of risks that patients should consider prior to authorizing the use of email and/or text messaging. These include, but are not limited to, the following risks:**

**a) Email and text messages can be circulated, forwarded, stored electronically and on paper and broadcast to unintended recipients b) Senders can easily misaddress an email/text and send information an undesired recipient c) Backup copies of emails and texts may exist even after the sender has deleted their copy d) Employers and online services (email or telephone provider) have the right to inspect emails/text sent through their system. Email and texts can be intercepted, altered, forwarded and used without authorization or detection e) Email/ texts can/may be used as evidence in court f) Though we use HIPAA protected services, email and texts can potentially be breached by a third party and affect confidentiality. Conditions for email and texts cannot be guaranteed, but reasonable means will be used to maintain security and confidentiality of email and text information that is sent and received. This practice and its representatives are not responsible for improper disclosure of confidential information that is not caused by our intentional misconduct.**

**Email and text messaging is not appropriate for urgent or emergency situations. This practice and its representatives cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.**

**Email and text messages should be concise. The patient/parent/legal guardian should call the practice to discuss complex or sensitive situations and/or to schedule any appointments.**

**All email and text messages may be printed and filed into the patient's dental/medical record. The Provider and its representatives will not forward patient/parent/legal guardian's emails and/or texts without their written consent, except as authorized by law. Patient/parent/legal guardians should not use email or text messages for communication of sensitive medical information. The Provider and its representatives are not liable for breaches of confidentiality caused by the patient/parent/legal guardian or any third party. It is the patient/parent/legal guardian's responsibility to follow up with email and/or texts and/or the scheduling of appointments if warranted. This Practice and its representatives are not responsible for any fees incurred as a result of any/all electronic transmissions.**

**I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or text messages between the dental practice and me, and consent to the conditions and instructions outlined in this document. I give my permission for the dental practice to text or email me at any phone numbers or emails provided by me.**

**I understand the above information and agree with its contents, and this will serve as my signature.**

**Signature: _____ Date: _____**

# HIPAA NOTICE OF PRIVACY PRACTICE



**THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by the law. It also describes your right to access and control your protected health information. Protected Health Information is about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.**

**Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your dentist, our office staff and others outside our office that are involved in your care and treatment to provide health care services to you to pay your health care bills, to support the operation of the dental practice, and any other use required by law.**

**Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes coordination or management of your healthcare with a third part. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.**

**Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for the hospital stay may require that your relevant protected information be disclosed to the health plan to obtain approval for hospital admission.**

**Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign in and indicate your dentist. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.**

**We may use or disclose your protected health information in the following situations without your authorization. These situations include: As required by law, Public Health issues as required by law, Communicable diseases, Health Oversight, Abuse or Neglect, FDA Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and hen required by the Secretary or the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.**

**Other Permitted Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your dentist or the dentist's practice ahs taken an action in reliance on the use or disclosure indicated in the authorization.**

**Your Rights**

**The following is a statement of your rights with respect to your protected health information: You have the right to inspect and copy your protected health information. Under the federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in**

**reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information. You have the right to request a restriction of your protected health**

**information. This means that you may ask us not to use or disclose part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request if the dentist believes it is in your best interests to permit use and disclose of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.**

**You have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of said rebuttal.**

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

**We reserve the right to change the items of this notice and will inform you by mail or email of any changes. You then have the right to object or withdraw as provided in this notice.**

**Complaints - You may complain about us to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.**

**This notice was published and became effective on or after June 1, 2012.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPM compliance officer in person or reach us by phone at our practice phone number. If you would like to permit any individual consent to access your health record, please indicate the individual(s) on your "Demographics" form. Please note, consent will remain on file until an updated form is completed.**

**I understand the above information and agree with its contents, and this will serve as my signature.**

**Signature: _____ Date: _____**