PATIENT INFORMATION

First Name:_____Last Name:_____

Middle Initial:_____Date of Birth:_____/_____/_____Sex: M ☐ F ☐

Address:_____

City:_____State:_____Zip Code:_____

Phone:_____E-mail:_____

Preferred Pharmacy: _____

City: _____ Pharmacy Phone: _____

***You will receive a text and/or e-mail regarding your future appointments. PLEASE CONFIRM or call to reschedule when you receive these notifications. If you do not confirm 3 days prior to your appointment, it will be CANCELLED.**

IN CASE OF EMERGENCY, CONTACT

Name:_____Relationship:_____

Emergency Contact Phone:_____

RESPONSIBLE PARTY INFORMATION

First Name:_____ Last Name:_____

Date of Birth:_____/_____/_____

Social Security Number: _____-_____-_____

DENTAL HISTORY:

Reason for today's visit: _____

Date of last dental visit:_____Date of last dental x-rays:_____

How did you hear about us?_____

How often do you floss?_____How often do you brush? _____

Check (☑) if you have/ had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐Bleeding gums	☐ Loose teeth or broken fillings	☐Sensitivity to cold
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Food collection between teeth
☐ Sensitivity when biting	☐Sores or growths in your mouth	☐ Sensitivity to sweets

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a blood thinner?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Sulfa Drugs ☐ Metal

☐ Latex ☐ Acrylic ☐ NSAIDS ☐ Codeine

☐ Local Anesthetics

Do you use controlled substances?	☐	If yes
Other?	◯ Yes ◯ No	

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Financial Responsibility and Authorization for Signature on File

If you have dental insurance, we will file the claims for you, as a complimentary service. It is patient's responsibility to provide the correct insurance at the time of appointment. It is also the patient's responsibility to update any insurance changes with Healthy Smiles NWI at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Healthy Smiles.

We will provide you with an **ESTIMATE** of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will cover these services. Please note that any difference in payment from your insurance company and your account is your responsibility and **payment will be due on the day of service**. **All major credit/debit cards are accepted. WE DO NOT ACCEPT CASH OR CHECK PAYMENTS.** While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility. In addition, you are financially accountable for any service that is non-covered on the day of that service.

Payment for co-pays and/or deductibles is due at the time services are provided. Any balance older than 90 days will be subject to being sent to a collection agency or an attorney. **Any attorney or collections fees incurred due to delinquency in payment or collection efforts will also be charged to you, including court costs and fees. Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic." Appointment time is reserved for you alone. When you make an appointment, please be sure that you will be able to keep it. If you are more than 15 minutes late we will have to reschedule you.**

Please make a note of any dental appointments you have scheduled and keep in a place where you will be easily reminded. In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. Repeated cancellations or missed appointments will result in loss of future appointment privileges. **If you have two failed appointments, you will be put on a short call list for any future treatment needs. If you are more than 15 minutes late to an appointment you will need to be rescheduled.**

Patient's Name_____ / / _____

First ***Last*** ***M.I.*** **DOB**

Signature X_____ / / _____

Patient / Guardian Signature **Today's Date**

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the office of ***Nicholas Cain, DDS at Healthy Smiles of Northwest Indiana***.

This "Signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original. I know I have a right to receive a copy of this authorization upon request. My signature also applies to any dependents listed on this form. I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information in connection to this claim.

INITIAL CONSENT FOR TREATMENT

INSTRUCTIONS: PLEASE READ AND REVIEW INFORMATION PROVIDED IN THIS DOCUMENT. ASK QUESTIONS FOR ANY ITEMS YOU NEED FURTHER EXPLANATION ON.

Examination, X-rays & Diagnosis

I understand that radiographs are a necessary part of the diagnosis process and consenting to have any dental x-rays is necessary. I understand that the examination and diagnosis process includes tooth charting, oral cancer screening and periodontal probing and I consent to this process.

I understand that I will be given the opportunity to ask questions regarding my treatment diagnosis. Also, any fees associated with treatment will be discussed with the receptionist when I check out.

Oral Hygiene

I understand that the long-term success of treatment and status of my oral condition depends strongly on my efforts to maintain proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits as recommended by my dental care provider.

General Consent

I understand that only the patient is allowed in the treatment room unless otherwise stated by the dental team.

I understand that any insurance benefits quoted are not a guarantee of benefits, but rather an estimate based on the information provided to our office by your insurance carrier. I understand I will be financially responsible for any amount(s) not covered by my insurance carrier.

I understand that this facility provides dental care services without discrimination based on race, religion, color, nationality, sex, sexual orientation, physical or mental disability, and/or age, and protects the privacy of each of its individual patients.

I certify that I have had the opportunity to read and fully understand the terms and conditions outlined within this document, and consent to cooperation and/or explanation referred to or made. I have been encouraged to ask questions and have had them answered to my satisfaction.

_____

PRINT PATIENT'S NAME

_____

PATIENT (OR PARENT/GUARDIAN) SIGNATURE Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
HEALTHY SMILES OF NORTHWEST INDIANA
Nicholas Cain, D.D.S.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I also hereby authorize the dental practice named above to discuss my dental treatment information and,
Dental financial information (which includes all information classified as Protected Health Information or PHI under the federal law HIPPA) at said dental practice with the following persons who shall be active in my dental care. I understand that to revoke this authorization, I must notify the dental practice above in writing.

_____ _____
Name of authorized recipient Relationship

_____ _____
Name of authorized recipient Relationship

_____ _____
Patient or Parent/guardian signature Date

_____
Printed Name of Patient