cicero
FAMILY DENTAL
411 N Peru Street, Cicero, IN 46034

Date_____

Patient Information: (CONFIDENTIAL)

Name_____MI_____ Birthdate_____ SS#_____
Address_____City_____State_____Zip_____
Email_____ Home Ph_____ Cell Ph_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Person to contact in case of emergency?_____Relationship_____ Phone _____

Responsible Party:

Person responsible for account_____Relationship_____
Address_____City_____State_____Zip_____
Email_____Cell Ph_____Home Ph_____
Birthdate_____ Work Phone_____ SS#_____
Is this person currently a patient in our office? ☐ Yes ☐ No

How did you hear about our office?

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have another insurance coverage, complete this for 2nd coverage**
Insured's name	**Insured's name**
Insured's employer	**Insured's employer**
Insurance Co	**Insurance Co**
Insurance Co Address	**Insurance Co Address**
Phone #	**Phone #**
SS#	**SS#**
Group # **Local #**	**Group #** **Local #**

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options. ☐

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 40%.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is a s accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, or Discover at the time we provide the service to you.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

Patient Signature (Parent if child)_____ **Date**_____

Patient's Name: _____

DENTAL/MEDICAL HISTORY

Are you under a physician's care? What for?_____ **Family Physician** _____ **Phone Number** _____
_____

What medications are you currently taking?_____ **Women: Are you pregnant?** No
_____ **Are you nursing?** No **Contraceptives?** No

Are you on a special diet? No **Do you use tobacco? How much per day/week?** 0 **Do you use controlled substances?** No

Do you drink alcohol? No **Do you have difficulty opening your mouth?** No **Do you clench or grind your teeth?** No

Have you had difficulty with dental extractions, prolonged bleeding post-operatively in the past? No

Have you ever been advised by a physician to take PRE-MEDICATION before any dental appointments? No **Reason?** _____

Would you like to discuss cosmetic smile enhancement? No

Please check items below if you have or have had any of the following:

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

Other: _____

Are you allergic or have you reacted adversely to any of the following medications:

Aspirin ☐	Codeine ☐	Sedatives ☐	Local Anesthetics ☐
Iodine ☐	Penicillin ☐	Sulfa Drugs ☐	Erythromycin ☐
Tetracycline ☐	Any Metals ☐	Barbiturates ☐	Latex Rubber ☐

Other: _____

Have you ever taken any of the following medications or any other Bisphosphonates?:

Actonel ☐	Aredia ☐	Boniva ☐	Fosamax ☐
Zometa ☐	Reclast ☐	Herbal Supplements ☐	

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate and verbally consent by patient or legal guardian to be used by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated pending I give verbal consent and/or sign the appropriate consent forms for surgical procedures. I also understand the use of anesthetic agents embodies a certain risk and are associated with any dental procedure requiring anesthetic. Though the risks are very low, I, the patient, agree to ask questions of the doctor before administration of any drug or anesthetic should I have additional concerns or require further clarity. I have read, understand and agree to the above terms and conditions.

_____ _____ _____

Patient Signature **Date** **Dentist Signature**

{Cicero Family Dental}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
{Please Print Name} Relationship

_____ _____
{Please Print Name} Relationship

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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