PATIENT INFORMATION

Date: ______________________ ☐NEW PATIENT ☐UPDATE

Patient: ____

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

____

PARENT/GUARDIAN NAME(S) (DOB)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

____

SCHOOL/LOCATION

Patient Date of Birth: ______________________ Patient SSN: ______________________

Address: ____

ADDRESS LINE 1

____

ADDRESS LINE 2

____

CITY ST ZIP CODE

HOME: ______________________

CELL: ______________________

OTHER: ______________________

: ______________________

: ______________________

E-Mail: ____

Referral? ☐Yes ☐ No Referred by: ______________________________________

EMERGENCY CONTACT

NAME:___________________________**RELATIONSHIP:**__________________________**TEL:**________________________

IDEAL SMILE QUESTIONAIRE

PLEASE TAKE A FEW MOMENTS TO TELL US ABOUT YOUR SMILE

HAVE YOU THOUGHT ABOUT IMPROVING THE APPEARANCE OF YOUR SMILE? YES:_____ NO:_____

WOULD YOU LIKE TO STRAIGHTEN YOUR TEETH? YES:_____ NO:_____

DO YOU HAVE SPACES THAT YOU DO NOT LIKE? YES:_____ NO:_____

WOULD YOU LIKE TO CHANGE THE COLOR OF YOUR TEETH? YES:_____ NO:______

WHAT WOULD YOU CHANGE ABOUT YOUR TEETH? (CIRCLE ALL THAT APPLY)

COLOR SHAPE SIZE STRAIGHTEN OTHER:_______________________________

Dental/Medical History

Patient Name ____ **Date of Birth** _________________________

Dental History

What is the reason for today's visit? ____

1.) Are you taking any prescription and/ or over the counter medications? ☐ No ☐ Yes
If yes, please list ____
2.) Are you allergic to any medications? ☐ No ☐ Yes
If yes, please list ____
3.) Are you allergic to any foods or materials? ☐ No ☐ Yes
If yes, please list ____
4.) Have you had any major surgeries in the past? ☐ No ☐ Yes
When? _________________________ Reason? ______________________
5.) Have you taken Fosamax, Boniva, Actonel, Or any other medications containing bisphosphonates? ☐ No ☐ Yes

6.) Do you use a vaping or electronic cigarette product? Frequency______________ ☐ No ☐ Yes

7.) Do you use marijuana? Frequency____ ☐ No ☐ Yes

Women: Are you……?

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

Are you allergic to the following?

☐Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa ☐ Local anesthetic

☐ Other? ____

Have you ever been told you need to take an antibiotic before dental treatment? ☐ No ☐ Yes

Have you had any history or ever been diagnosed with any of the following:

☐ AIDS/HIV
☐ Alzheimer
☐ Artificial heart valve
☐ Artificial joint,
Date____________
☐ Asthma
☐ Anaphylaxis
☐ Angina
☐ Asthma
☐ Epilepsy/ seizure
☐ Cancer, type__________

☐ Chemotherapy
☐ Cold Sores
☐ Congenital heart disorder
☐ Excessive bleeding
☐ Excessive thirst
☐ Heart attack,
Date:_____________
☐ Heart murmur
☐ Pacemaker/defibrillator
☐ Heart disease/surgery
☐ Hemophilia
☐ Hepatitis A, B or C

☐ High Blood pressure
☐ High Cholesterol
☐ Hypoglycemia
☐ Kidney problems
☐ Leukemia
☐ Liver disease
☐ Low blood pressure
☐ Lung disease
☐ Mitral valve prolapse
☐ Osteoporosis
☐ Pain in jaw joints (TMJ)
☐ Radiation treatments

☐ Renal disease
Dialysis Days____________
☐ Sickle cell disease
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Tumors
☐ Yellow Jaundice
☐ Ulcers
☐ HPV
☐
☐ Other:
____
____

Patient signature: ____ **Phone** _________________

 Doctor's initials__________

Cornerstone Family Dentistry

Patient Name____Date___________________

Dental treatment is an excellent investment in an individual's medical and psychological well being. We realize that everyone's personal financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the care that you need and/or desire.

Insurance: We are happy to file the forms necessary to see that you receive the full benefits of your insurance coverage; however, <u>we cannot guarantee any estimated coverage.</u> Your insurance policy is an agreement between you, your insurance company, and your employer. We ask that all patients accept direct responsibility for all charges. You are required to meet the deductable, co-payments, and/or percent of estimated fees and non-covered services if applicable. If for some reason your insurance company has not paid their allowed benefits within *60 days form the start of treatment and/or you are denied benefits, you are responsible for your account balance*. It is the patient/ subscriber/cardholder's responsibility to notify our office if there are any insurance changes.

No Insurance: If you claim to not have insurance coverage, are not sure of coverage, or we are unable to verify insurance for services rendered you are responsible for all fees. You accept the fees that have been presented to you by Cornerstone Family Dentistry. You agree that Cornerstone Family Dentistry and/or Bryan Sigg D.D.S. will not be financially responsible for any balances associated with your account and will not reimburse you, if a crown or prosthesis is started and not completed.

Payment Options: For your convenience, we accept cash, checks, Visa, MasterCard, Discover, American Express, and Care Credit.

Care Credit Plan: For information on financial arrangements that extends credit for immediate treatment, usually interest free, please ask our business manager for details.

Cash/Check Discount: There is a 5% discount for all services paid with cash or check when no insurance is available.

Gradual Treatment Plan: Total patient responsibility divided into equal payments paid over number of appointments required. Final payment concluded at last appointment.

Cancellation/Appointment Failure Policy: If you cancel your appointment with less than 24 hour notice or if you fail an appointment there is a fee of $85.00 per appointment.

ITEX: There is a 20% material charge on all services rendered through ITEX.

Express Consent to Communication:

The Undersigned gives express consent for Eagle Accounts group and Cornerstone Family Dentistry ("creditor"0 to contact you at the phone numbers and emails listed in your patient accounts in connection with your business relationship with creditors. The term "contact" includes landline and cellular communications, leaving voicemails or answering machines, leaving messages with persons who answer phones authorized by you, text message communications, email messages communications, and similar methods of communications. The express consent also authorizes such communications to be sent by automated dialers and messaging equipment. This express consent also allows any agents, contractors, or attorney of creditors to contact you at the phone numbers or emails you provide to creditors for the purpose of resolving any unpaid balance owed to creditors. You may cancel this consent at any time by notifying creditors or, if applicable, by notifying an agent,contractor, or attorney of creditors that is in current contact with you.
If my account becomes delinquent, I will be responsible for collection agency fees and/or attorney/court fees. I also understand that there will be a charge of $25.00 for returned checks and a 1% finance charge applied monthly to all accounts balances over 60 days.

____________________ ______________________________ _______________________

Date Patient or Responsible Party Business Manager

Cornerstone Family Dentistry
Bryan Sigg, DDS
1201 N. Post Road Suite 6
Indianapolis, IN 46219
(317) 897-8970 phone (317) 897-8970 fax

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name____
Patient address____
Patient phone number____
Patient Email address____
I authorize the professional office of my dentist named above to release health information identifying me (including if applicable, information about HIV infection, or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:
1. Detailed description of the information to b released:
2. To whom may the information be released (name(s) or class(es) of recipients):
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state “at the request of the individual” as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:
It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.
If you sign this authorization, you can revoke it later: the only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to evoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.
When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.
(For marketing authorizations, include as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.)
I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.
Dated______________________Patient Signature___________________________________
If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:
Relationship to Patient_________________Print Name______________________________