BROWNSBURG
FAMILY DENTISTRY

Margaret Broderick, DDS- Olga Molin, DDS

Thank you for visiting Brownsburg Family Dentistry. We want your visit to be pleasant and comfortable.

Patient Information

First name: _____ Last name: _____

Address: _____
Street City Zip

Phone #: Hm: _____Work: _____ Cell: _____
May we contact you at work? YES NO

Date of Birth: _____ Social Security #: _____

Email address: _____May we confirm appts by email? Y or N
May we confirm by text? Y or N

Emergency contact name: _____ #:_____ Relationship: _____

Insurance Information

Primary Dental Carrier
Subscriber Name: _____ SS#: _____

Date of Birth: _____ Employer: _____

Insurance Name: _____ Insurance Phone #:_____

ID #: _____ Group #: _____

Relationship to patient: _____

Secondary Dental Carrier
Subscriber Name: _____ SS#: _____

Date of Birth: _____ Employer: _____

Insurance Name: _____ Insurance Phone #:_____

ID #: _____ Group #: _____

Relationship to patient: _____

Insurance Authorization Statement

I hereby authorize payment directly to the dental office of the group benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

If Patient is under 18
Responsible Party: _____Relationship to Patient: _____
Phone #: _____

Are you under a physician's care now? Yes No Doctor Name: _____

Doctor #: _____

Have you ever been hospitalized or had a major surgery? 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 _____

_____

What pharmacy do you prefer perceptions to be called into? Pharmacy name: _____

Pharmacy #:_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? Yes No

Are you on a special diet? Yes No

Women are you…. (Please circle any appropriate answers)

Pregnant Nursing Taking oral contraceptives

Are you allergic to any of the following? (Please circle any appropriate answers)

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Other _____

Do you use controlled substances? Yes No If yes _____

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

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

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

_____

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 _____

Dental Questionnaire

We appreciate the confidence you have placed with us to provide dental care for you.
All the information on this form is necessary for your records and is strictly confidential.

Are you in any discomfort?	YES	NO
Any sensitivity to hot, cold, sweets, or chewing?	YES	NO
Does dental treatment make you nervous?	YES	NO
Have you experienced any of the following…		
Bleeding gums	YES	NO
Bad breath	YES	NO
Soreness of jaw joint	YES	NO
Grinding of teeth	YES	NO
Do you think dental care effects your health?	YES	NO
Do you think 6 month cleanings are important?	YES	NO
Do you prefer to save your teeth?	YES	NO
Have you ever had sealants?	YES	NO
Is the brightness of your teeth important?	YES	NO
Do you drink coffee or tea?	YES	NO
If you could change your smile you would like to…		
Whiten	YES	NO
Straighten	YES	NO
Close gaps	YES	NO
Replace silver fillings	YES	NO
Repair chipped teeth	YES	NO
Replace missing teeth	YES	NO
Have less gums showing	YES	NO
Replace crowns that do not match	YES	NO

On a scale of 1-10, with 10 being the highest rating, please rate each of the following questions

How important is your dental health to you?	1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?	1 2 3 4 5 6 7 8 9 10
Where would you like your dental health to be ranked?	1 2 3 4 5 6 7 8 9 10

When was the last time you had an oral cancer screening? _____

Date of your last dental cleaning? _____

What did you like about your previous dental office? _____

What did you not like about your previous dental office? _____

If there was a way to whiten your teeth for a very reasonable investment, would you be interested? Yes No

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

Brownsburg Family Dentistry

DENTAL CARE YOU CAN SMILE ABOUT

Insurance and Financial Agreement

At Brownsburg Family Dentistry, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits, but some don't. If you have dental benefits, you are very fortunate. Here are some important things you should know:

Your dental benefits are based upon a contract made between your employer and an insurance company directly**. If you have questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans very rarely will pay for the total cost of your dental care. It is only meant to assist you. _____ Initial**

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept reduced fee for service). This means that we work with literally hundreds of companies**. It is your RESPONSIBILITY as the policy holder to understand your policy and know what your policy allows.** Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pretreatment authorization" with your insurance company prior to treatment. But keep in mind this is not a guarantee of coverage, and may **delay treatment**. _____ **Initial**

We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Brownsburg Family Dentistry reserves the right to request payment in full from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU** and your insurance. Our office is not and cannot be part of that legal contact. Ultimately, you are responsible for all charges incurred in our office. _____ **Initial**

Brownsburg Family Dentistry does require payment in full for your portion at the time of service. We accept; all major credit cards, cash and checks. If you are in need of an extended finance option, we also work with Care Credit, who offers 3,6,12 months "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. _____ **Initial**

A specific amount of time is reserved specially for you and we strongly encourage all patients keep their appointments. If you must change your appointment, we require at least 48 hour notice to avoid a cancellation fee. _____ **Initial**

Treatment Authorization

I have reviewed the information on this form and it is accurate to the best of my knowledge. I authorize and give consent for the dentist and/or team of this office to perform dental services as agreed between doctor and patient and/or guardian, including the use of local anesthetic and other medications as indicated.

Print Patient Name: _____ Date: _____

Patient/ Parent Signature: _____

MARKETING AND HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders such as voice mail messages, post cards, email or texts

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances

Patient Rights

ACCESS: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a photocopy format. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of the notice. If you request copies, we will charge you $20. If you request an alternative format to photocopying, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee, Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

DISCLOUSRE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment or healthcare operations and certain other activates for the last 7 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your held information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement except in an emergency.

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternate means. You must make your request in writing. You must specify the alternative means and provide satisfactory explanation how payments will be handled under the alternative means you request.

AMENDMENT: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this notice on our website or by electronic mail, you are entitled to receive this notice in written form as well.

QUESTIONS AND COMPLAINTS: If you need more information about our privacy practices or have questions or concerns, please call our office.

You may contact us directly if you feel any of the following have been violated;

- You disagree with a decision we made about access to your health information
- Or in response to a request you made to amend
- Or restrict the use or disclosure of your health information or to have us communicate with you by alternative means

Office Manager: Kelci Kelly

Telephone: 317-852-6620

Address: 1460 N. Green Street, Ste. 300 Brownsburg, IN 46112

Brownsburg Family Dentistry

1460 North Green St, Ste 300

Brownsburg, IN 46112

Acknowledgement of Receipt of Privacy Practices

*You May Refuse to Sign this Form

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

_____

Please Print Name

_____

Signature **Date**

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please specify)

_____

_____

_____