

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: __
Last, First MI (Preferred Name) Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
Address: _____
Street Apartment #
City State Zip Code

Health Information

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Growths | Due date: _____ | OTHER: _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> LIST |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | MEDICATIONS _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease | |
| | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Codeine Allergy | |

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street _____ City _____ State _____ Zip Code _____ Phone _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

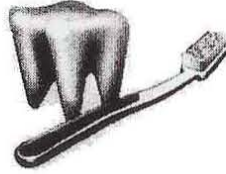
I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____

Patient, parent or legal guardian

If signed by patient representative, state relationship to patient _____



Mattingly Family Dentistry
957 E. Commercial Avenue
Lowell, Indiana 46356
219-696-0250

THE DENTAL OFFICE FINANCIAL POLICY:

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

GENERAL:

Understand that, regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes, but is not limited to, dental fees, surgical procedures, test, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 24 hours in advance (excluding emergencies) you will be charged \$30.00 per half hour. Please help us service you better by keeping your scheduled appointments.

RETURNED CHECKS:

Returned check policy for Mattingly Family Dentistry: Non-sufficient funds is \$ 30.00

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Insurance is not a guarantee of benefits.

As a courtesy to you, our office provides certain dental services, including pre-treatment estimates which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or the fees for the services being rendered, it is your responsibility to have these questions answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion. For any unpaid balances, your options for payment are:

1. Cash/ Check
2. Credit Card/ Debit Card
3. Care Credit (we can provide you with the paperwork to apply)

I have no dental insurance _____

I have dental insurance _____

UNPAID BALANCES OVER 60 DAYS ARE THE PATIENT'S RESPONSIBILITY. IF BALANCE IS NOT PAID AFTER 90 DAYS, ACCOUNTS WILL BE TURNED OVER TO COLLECTION.

I have read and fully understand the financial policy of Mattingly Family Dentistry.

Signature: _____ Date: _____