PITTSBORO
Family Dentistry

Dear New Patient,

We are delighted to have you as a new patient! We extend our sincere thanks for the opportunity to meet your dental needs. Our goal is to provide the highest quality dental care for all of our patients. We will do our best to provide you with same week appointments and same day for emergencies. You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. You will be asked to fill out new registration forms annually so we may update your information.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing specialist.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

We understand that appointments sometime need to be changed, so we ask that you call 24 hours in advance if you cannot keep your scheduled appointment. If you fail to cancel two (2) appointments in a row our policy states we must dismiss you from our practice.

Our Office Hours:

Monday 8am - 6pm
Tuesday 8am - 5pm
Wednesday 8am - 5pm
Thursday 7am - 5pm
Friday Closed
Saturday 8am - 1pm *One Saturday each month*
Sunday Closed

For after hour emergencies please call: 317-437-1053 and leave a detailed message.

Contact Us!
Address: 204. North Maple St. P.O. Box 314 Pittsboro, Indiana 46167
Tel: 317-892-4994 Fax: 317-892-4409
Email: dr.heath@pittsborofamilydentist.com
Website: www.pittsborofamilydentist.com

PATIENT REGISTATION

Patient ID:_____
First Name:_____Last Name:_____
Middle Initial:_____ Preferred Name:_____
Patient is _____Policy Holder_____Responsible Party

Patient Information:

First Name:_____Middle Initial _____Last Name:_____
Address:_____
City, State, Zip Code:_____
Home #:_____Cell #:_____
Birth Date:_____Social Security #_____ Drivers License #:_____

Responsible Party is also a Policy Holder for Patient _____Primary Insurance Policy Holder ____Secondary Policy Holder

Responsible Party Information: (If someone other than the patient)

Name:_____Address:_____
_____Home #:_____Cell#_____
Gender:_____Female_____Male
Birthdate:_____Age:_____ Social Security #_____Drivers License #_____
Preferred Method Of Contact For Appointment
Reminders:__Text__Call__Email:_____

Responsible Party Employment Status:

___Full Time___Part Time_____Retired____Student
Work Name:_____Work Address:_____
City, State, Zip Code:_____
Work #_____Ext:_____

Primary Insurance Information

Name of Insured:_____Relationship to Insured:_____ Insured
Social Security #:_____Insured Birth Date:_____
Insurance Company Name:_____
Insurance Address:_____

Secondary Insurance Information

Name of Insured:_____Relationship to Insured:_____
Insured Social Security #:_____Insured Birth Date:_____
Insurance Company Name:_____
Insurance Address:_____

Medical History

PATIENT NAME_____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No Taking oral contraceptives ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ◯ 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 _____

Cosmetic Concerns

Do you have staining you would like to removed?	Yes	No
Do you have wearing or chipping on your front teeth you need repaired?	Yes	No
Do you want dark metal fillings replaced?	Yes	No
Do you have dark spaces or triangles between your teeth?	Yes	No
Do you have missing teeth you would like to replace?	Yes	No
Do you have teeth you want your teeth straightened?	Yes	No

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 _____ DATE _____

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize **Pittsboro Family Dentistry** to release health information identifying me under the following terms and conditions:

1. **Detailed description** of the information to be released: X-rays, doctor treatment notes if needed, periodontal charting etc.

2. **To whom** may the information be released (name(s) or class(es) of recipients): Practices may include but are not limited to; Oral Surgery, Periodontics, Endodontics, Orthodontics or General Dentistry.

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): Patient referral to specialists that include but are not limited to: Oral Surgery, Periodontics, Endodontics, Orthodontics or General Dentistry.

4. Expiration date or event relating to the individual or purpose for the release: Referral to specialist for treatment purposes.

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 revoke authorization, send us a written or electronic note telling us that your authorization is revoked.

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.

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.

Signature:_____Date:_____
Patient, parent or legal guardian

Relationship to patient:_____

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The financial policy of Pittsboro Family Dentistry is that payment is expected at the time service is rendered.

Should you have insurance, you need to remember that it is a contract between you and the carrier and we are not part of that contract. Your insurance is a means of payment and not a transfer of your personal responsibility. We cannot render services on the assumption that the charges will be paid by the insurance company. You, as the patient, are personally responsible for the payment. We will submit necessary claims and narratives to assist in making collections from you insurance company.

To serve all of our patients we have contracts with a number of insurance companies. None of these insurance companies provide the same service for the subscriber and their family members. Co-pays, annual deductibles, and the rate of reimbursement vary between the different companies. These differences are the reason you as the policy holder are personally responsible to know what your insurance covers at your time of your appointment.

If you disagree with your carrier's settlement of your claim, you will need to pay the balance due and appeal directly to your carrier. Besides payment through your insurance company we accept payments by CASH, CHECK, and CREDIT CARD. If a payment plan is necessary to satisfy your debt, we can make arrangements. If your debt cannot be satisfied we will seek the assistance of a collection agency.

I authorize the release of any information deemed necessary to assist in my treatment to my insurance company, should they request it. Even though I have insurance coverage, I understand that actual benefit determinations are made when services are rendered and are subject to change due to patient eligibility, plan and frequency limitations, maximum and deductible and other coverage at the time services are rendered.

I understand and agree that I will be held financially responsible for any balances incurred in this office that are covered but not paid by my insurance company or for charges that are considered to be cosmetic. I agree to pay any and all costs associated with the collection of debt incurred including, but not limited to, collection agency fees, attorney fees and court costs as applicable.

_____(Initial) **Once an account is delinquent for over 90 days we will send you a collections letter notifying you of our intentions to turn your account over to collections. You must respond within 30 days of that date to pay your balance or notify us of your payment status. Failure to respond within 30 days results in collection services. Employer:_____Tel:_____**

I certify that I have read this document, understand its contents, and agree to my responsibilities.

_____Date:_____

Signature of patient or person responsible for payment

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 12/19/2016, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact our office.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information using the information listed at the end of this Notice.

Disclosure 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, healthcare operations and certain other activities, for the last 6 years, but not before 12/19/2016. 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 health information. We are not required to agree to these additional 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 alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or 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 or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Address: 204 North Maple St Pittsboro, In 46167
Telphone Number: 317-892-4994
Fax Number: 317-892-4409
Website: www.pittsborofamilydentist.com
Email: Dr.heath@pittsborofamilydentist.com

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I, _____acknowledge that I have received a copy of Dr. David Heath's Notice of Privacy Practices for services rendered at Pittsboro Family Dentistry.

Patient name printed:_____

Patient signature: _____

Date:_____

I authorize release of information to the following:

Name & Relationship to Patient:

_____

_____

_____

_____

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