Patient Information

Patient's Name: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Marital Status: _____

Employer: _____ Occupation: _____

Spouse's Name: _____Spouse DOB:_____

Spouse Employed by: _____ Business Phone: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Who may we thank for referring you? _____

Dental Insurance Company: _____

Secondary Dental Insurance Company: _____

By signing below, I guarantee that the information presented above is accurate.
By signing below, I give this office permission to submit information to the insurance company(s) listed above and to collect fees for the services provided.
By signing below, I agree that I am responsible for all fees not paid by my insurance including but not limited to deductibles, co-pays, non-covered services, and disallowed services; any interest or fees assessed to my account for past due balances, returned checks, and any and all fees incurred as a result of the use of a collection agency.

Patient Signature Date

Health History

Patient's Name: _____ **DOB:** _____

Physician's Name: _____ **Phone number:** _____

Date of last exam: _____ **For what purpose?** _____

Do you have any known drug allergies (latex, penicillin, etc.)? ☐ yes ☐ no

If yes, please list/explain reaction: _____

Do you have any artificial joints? ☐ yes ☐ no
Do you use tobacco currently? ☐ yes ☐ no **Are you interested in quitting?** ☐ yes ☐ no
Have you used tobacco in the past? ☐ yes ☐ no **Packs/Day** _____
Do you use any other controlled substances? ☐ yes ☐ no
Do you have a pacemaker? ☐ yes ☐ no
Are you subject to fainting? ☐ yes ☐ no
Do you have prolonged bleeding? ☐ yes ☐ no

Have you ever been diagnosed with:

☐ AIDS/HIV
☐ Anemia
☐ Angina
☐ Arthritis/gout
☐ Artificial heart valve
☐ Asthma
☐ Cancer
☐ Congenital Heart Disorder
☐ Diabetes last A1c _____
☐ OTHER

☐ Drug addiction
☐ Epilepsy/seizures
☐ Glaucoma
☐ Heart attack/failure
☐ Heart disease/trouble
☐ Heart murmur
☐ Hepatitis
☐ High blood pressure
☐ High cholesterol

☐ Low blood pressure
☐ Mental illness
☐ Osteoporosis
☐ Rheumatic Fever
☐ Sinus trouble
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers

Please explain: _____

_____

Please list all medications you are taking: _____

_____

WOMEN – are you:
☐ pregnant ☐ nursing ☐ taking oral contraception

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

Patient Signature **Date**

Dental Health History

Patient's Name: _____Today's Date: _____

Date of last dental visit: _____ Previous Dentist: _____

Are you having any discomfort at this time? ☐ yes ☐ no

Describe Discomfort: _____

Does dental treatment make you nervous? ☐ yes ☐ no

If so, are you interest in using nitrous oxide (laughing gas) and/or sedation during treatment? ☐ yes ☐ no

Have you ever had any serious trouble with previous dental treatment? ☐ yes ☐ no

If yes, please explain: _____

Have you ever been treated for periodontal disease (gum disease)? ☐ yes ☐ no

If yes, when? _____

Have you ever had any teeth removed? ☐ yes ☐ no **When? _____**

Were the removed teeth replaced? ☐ yes ☐ no **Was it suggested?** ☐ yes ☐ no

How often do you brush? _____ How often do you floss? _____

Are you having problems with or concerned with any of the following:

☐ bleeding/sore gums	☐ biting your cheeks/lips	☐ dry mouth
☐ unpleasant/bad breath	☐ clicking/popping jaw	☐ clenching/grinding
☐ teeth sensitive to sweets	☐ complete/partial dentures	☐ chewing nails/objects
☐ blisters in mouth/lips	☐ loose teeth	☐ burning tongue/lips
☐ change in bite	☐ teeth sensitive to hot/cold	☐ teeth sensitive to chewing
☐ difficulty opening/closing	☐ food packing between teeth	☐ swellings in mouth

Are you pleased with the appearance of your teeth? ☐ yes ☐ no

If not, what would you like to change? _____

Are you interested in whitening your teeth? ☐ yes ☐ no

Please note that it is your responsibility to update any changes to your dental information.

Office Policy

Payment is due at the time service is provided, unless previous arrangements have been made. Our office accepts cash, check, VISA, MasterCard, Discover, American Express, and Care Credit.

If you have dental insurance, as a courtesy, we will assist you in processing claims on your behalf. In order for our office to file your insurance claim, you must bring your insurance card to each appointment and alert our office to any changes in your insurance provider or policy. Any co-payment that is the patient's responsibility is due when the service is provided unless other arrangements have been made.

If you are unable to keep a scheduled appointment, please contact our office 2 business days in advance. In the event of multiple missed or broken appointments, our office reserves the right to assess a fee on the patient's account.

In the event the patient (or family member) has a balance on their account, a billing statement will be mailed. If no payment is made on the account before the due date, a re-billing fee may be assessed for subsequent billing statements.

If you have any questions regarding our policy, please do not hesitate to ask.

Patient Signature Date

Joseph Keck DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name:_____

Address:_____

Telephone:_____ Social Security No._____

Section B:**TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.
Notice of privacy practices: You have the right to read our notice of privacy practices before you decide to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our notice of privacy practices, including any revisions of our notice, at any time by contacting:

Contact Person: Tammy Threlkeld Telephone: 765-436-2433 Fax: 765-436-2551

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand the revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____ have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

SIGNATURE_____**DATE**_____

If this Consent is signed by a Personal Representative on behalf of the patient, complete the following;

PERSONAL REPRESENTATIVE'S NAME:_____

RELATIONSHIP TO PATIENT:_____

You are entitled to a copy of this consent after you sign it.