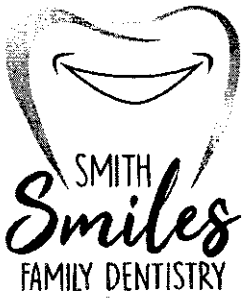

Dr. Heather Smith, DMD
9020 E. Washington St.
Indianapolis, IN 46229
317-897-3066

WELCOME

Thank You for Choosing Our Dental Team!

We strive to provide you with the best dental care. To help us meet your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, we will be happy to help you.

PATIENT INFORMATION

Name_____ **Sex** ☐ **F** ☐ **M** **Birthdate**___/____/_____ **Age**_____

Address_____ **City**_____ **State**_____ **Zip** _____

Cell phone_____ **Home phone**_____

E-Mail _____ **SS#**_____

Contact preference/s? ☐ **Cell/Text** ☐ **Home** ☐ **Email** **How did you hear about us?**_____

☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** ☐ **Minor** **Employer**_____

Emergency contact _____ **Contact phone**_____

RESPONSIBLE PARTY

Person responsible for the account_____ **Relationship to patient** _____

Birthdate___/____/_____ **Sex** ☐ **F** ☐ **M** ☐ **Transgender** ☐ **Genderqueer** ☐ **Other** ☐ **Choose not to disclose**

Address_____ **City**_____ **State**_____ **Zip**_____

Cell phone_____ **Home phone**_____ **SS#**_____

Contact preference/s? ☐ **Cell/Text** ☐ **Home** ☐ **Email** **E-Mail**_____

INSURANCE INFORMATION

Policy holder_____ Relationship to patient _____

Birthdate____/_____/_____ SS#_____ Insurance company _____

Policy ID #_____ Insurance phone _____

Insurance address_____ City_____ State_____ Zip_____

- **If you have additional insurance complete below:**

Policy holder_____ Relationship to patient _____

Birthdate____/_____/_____ SS#_____ Insurance company _____

Policy ID #_____ Insurance phone _____

Insurance address _____ City _____ State_____ Zip_____

DENTAL HISTORY

Former dentist_____ Date of last exam_____ Do you have current x-rays? ☐ **Y** ☐ **N**

How often do you brush?_____ How often do you f loss?_____

☐ **Y** ☐ **N** Do you want straighter teeth

☐ **Y** ☐ **N** Difficulty opening, closing, or chewing

☐ **Y** ☐ **N** Sensitivity to hot, cold, sweets or pressure

☐ **Y** ☐ **N** Bleeding gums when you brush or floss

☐ **Y** ☐ **N** Sores or lumps in or near your mouth

☐ **Y** ☐ **N** Problems with prior dental treatment

☐ **Y** ☐ **N** Difficult/prolonged bleeding with extractions

☐ **Y** ☐ **N** Jaw clicking, popping, pain (joint, ear, headaches, side of face)

☐ **Y** ☐ **N** Injury to head, neck, or jaw: Specify and when?_____

☐ **Y** ☐ **N** Do you wear dentures or partials: Specify and date of placement_____

☐ **Y** ☐ **N** Do you want whiter teeth

☐ **Y** ☐ **N** Frequent cheek or lip biting

☐ **Y** ☐ **N** Periodontal (Gum) treatment

☐ **Y** ☐ **N** Dry mouth

☐ **Y** ☐ **N** Dental anxiety

☐ **Y** ☐ **N** Tooth pain

☐ **Y** ☐ **N** Grind or clench

☐ **Y** ☐ **N** Have you had braces

☐ **Y** ☐ **N** Do you snore

MEDICAL HISTORY

Name of physician_____ Office phone_____

General health: ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor** **Have you had the Covid vaccine?** ☐ **Y** ☐ **N**

Is pre-medication required before your dental appointments due to artificial joint placement, etc? ☐ **Y** ☐ **N**

Are you under a physician's care now? ☐ **Y** ☐ **N** If yes, explain_____

Have you had any serious illnesses, surgeries, or hospitalizations? ☐ **Y** ☐ **N** If yes, explain _____

_____

CHECK IF PAST OR PRESENT **CHECK BOX IF NONE** ☐

☐ Respiratory disease: Specify_____
☐ Neurological disorder: Specify_____
☐ Osteoporosis/ Osteopenia
☐ Stroke: When _____
☐ Arthritis/Rheumatism
☐ Gastrointestinal disease: Specify_____
☐ Autoimmune disorder: Specify_____
☐ Mental health disorder: Specify_____
☐ Smoke/Chew/Vape, Tobacco or Marijuana: Specify _____
☐ Substance abuse: Specify_____
☐ Sleep disorder: Specify_____
☐ Cancer: Specify_____

☐ Thyroid disease/malfunction
☐ Epilepsy/Seizures
☐ Fainting/Dizziness
☐ AIDS/HIV infection
☐ Blood disease/ disorder
☐ Headaches/Migraines
☐ High Cholesterol
☐ Diabetes ○ Type I ○ Type II
☐ High blood pressure
☐ Chest pain/ Shortness of breath
☐ Kidney disease/malfunction

☐ Spinal fusion/ injury
☐ Sinus problems
☐ Hearing problems
☐ Persistent cough
☐ Swollen glands in neck
☐ Tuberculosis
☐ Hepatitis/Jaundice
☐ Liver disease
☐ Asthma
☐ Acid reflux
☐ Ear infections

Did You Undergo ○ Chemotherapy ○ Radiation

☐ Joint and/or Implant replacement (Hip/Knee/Elbow/Finger, etc): Specify and when_____

Cardiovascular disease, Specify below

☐ Afib ☐ Congenital heart defect ☐ Damaged heart valves ☐ Mitral valve prolapse
☐ Arteriosclerosis ☐ Congestive heart failure ☐Heart murmur ☐ Pacemaker
☐ Artificial heart valve ☐ Coronary artery disease ☐Heart attack ☐ Rheumatic fever/ Rheumatic heart disease

WOMEN ONLY: Pregnant ☐ **Y** ☐ **N** Nursing ☐ **Y** ☐ **N** Birth control pills ☐ **Y** ☐ **N** Hormonal replacements ☐ **Y** ☐ **N**

MEDICATION **CHECK BOX IF NONE** ☐

- **Are you taking or have you taken BONE DENSITY medications such as but not limited to?** ☐ **Y** ☐ **N**

  ☐ **Actonel** ☐ **Aredia** ☐ **Bonefos** ☐ **Boniva** ☐ **Fosamax** ☐ **Skelid** ☐ **Zometa** ☐ **Reclast** ☐ **Didronel** ☐ **Prolia** ☐ **Aredia** ☐ **Xgeva**

- **Are you taking or have you taken any DIET DRUGS such as but not limited to?** ☐ **Y** ☐ **N**

  ☐ **Pondimin** ☐ **Anti-osteoporosis** ☐ **Fen-Phen** ☐ **Redux**

- **LIST OF MEDICATIONS, OTC MEDICATIONS, AND VITAMINS:** ❖ **YOU CAN PROVIDE A LIST TO THE OFFICE** ❖

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES **CHECK BOX IF NONE** ☐

☐ Local anesthetics ☐ Penicillin/Antibiotics ☐ Sulfa drugs ☐ Latex ☐ Iodine ☐ Aspirin ☐ Codeine/ Narcotics
☐ Metals (nickel, mercury, etc) ☐ Barbiturates/ Sedatives/ Sleeping pills ☐ Seasonal ☐ **Other** _____

- **PLEASE LIST ANY ADDITIONAL MEDICAL HISTORY INFORMATION NOT LISTED ON THIS FORM?**

_____

AUTHORIZATION AND RELEASE

Payment is due in full at the time service unless payment arrangements are approved. I understand that I am financially responsible for payment of all services rendered not paid by my insurance. I hereby authorize release of any information of treatment rendered to my insurance company. To the best of my knowledge, all the preceding answers are correct. I understand it is my responsibility to inform the office of any changes in my medical health or insurance. I authorize the dental staff to perform any necessary dental services that I may need with my informed consent.

×_____ × _____ ☐ **Please check the box that you have read**

Signature of Patient/Parent/Legal Guardian **Date** **and understand the Notice of Privacy Practices**

Dr. Heather Smith, DMD
9020 E Washington St.
Indianapolis, IN 46229
317-897-3066

HIPPA Compliance Patient Consent

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. Please list who you give Smith Smiles Family Dentistry permission to communicate the following information regarding yourself or your child. This information may be subject to re-disclosure by the listed individuals, and the disclosed information is then beyond the privacy protections of the practice.

Authorized Individual	**Relationship to Patient**	**Phone Number**

The above individual may receive the following information: ***Please check all that apply***

- ☐ **All information listed below**
- ☐ Appointment information only
- ☐ Dental health, dental treatment, and prescription information only
- ☐ Account and billing information only

Authorized Individual	**Relationship to Patient**	**Phone Number**

The above individual may receive the following information: ***Please check all that apply***

- ☐ **All information listed below**
- ☐ Appointment information only
- ☐ Dental health, dental treatment, and prescription information only
- ☐ Account and billing information only

Authorized Individual	**Relationship to Patient**	**Phone Number**

The above individual may receive the following information: ***Please check all that apply***

- ☐ **All information listed below**
- ☐ Appointment information only
- ☐ Dental health, dental treatment, and prescription information only
- ☐ Account and billing information only

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing at any time and all full disclosures will then cease.

Patient Name

Signature of Patient/Parent/Legal Guardian **Date**

Dr. Heather Smith, DMD
9020 E Washington St.
Indianapolis, IN 46229
317-897-3066

MISSED APPOINTMENT & LATE CANCELLATION POLICY

Dr. Smith wants our patients to know how much we value your business. Your scheduled appointments are reserved specifically for you. In an effort to provide the highest quality of dentistry we require a **48 HOUR NOTICE** for any scheduled appointment changes.

Our office understands that sometimes emergency situations arise, and we will handle each circumstance on an individual basis. We would like our patients to understand that missed and late cancellation appointments delay your treatment and our ability to keep your oral health at optimum levels. Also, they prevent other patients, who need treatment, from getting the necessary care in a timely manner.

With this in mind, we want you to be informed of our appointment policy so that there are no misunderstandings in the future:

1. We reserve the right to charge for appointments that are missed or cancelled without a 48 hour notice.
2. Multiple cancellations and broken appointments may result in a dismissal from the practice.
3. We understand emergencies arise unexpectedly, and we will carefully assess each situation.

I have read and understand the above policy.

x_____ _____

Signature of Patient/Parent/Legal Guardian **Date**

Google Review Consent

Smith Smiles Family Dentistry would like your permission to post your google review on our website and social media platforms such as Facebook, Instagram, and YouTube.

I hereby authorize Smith Smiles Family Dentistry to post my google review on their social media platforms and website for marketing purposes.

My consent is freely given as a public service to Smith Smiles Family Dentistry, without expecting payment.

x_____ _____

Signature of Patient/Parent/Legal Guardian **Date**

TRUTH IN LENDING
EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES

INTEREST RATES AND INTEREST CHARGES	
Annual Percentage Rate (APR) for Purchases	**15.00%**
Paying Interest	A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown.
Minimum Interest Charge	**If you are charged interest, the charge will be no less than $0.50**

FEES	
Late Charge	**$5.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $17.50** If the minimum payment is received within 10 days after the due date the late charge will be waived.
Non-Sufficient Funds (NSF) Fee	**$25.00 per payment**

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights. In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Smith Smiles Family Dentistry

Dental Entity Name

Signature

Date

A photocopy of this document may act as an original

Form 05304IN (7-1-17)