CONFIDENTIAL **PATIENT INFORMATION** **PLEASE PRINT**

CIRCLE ONE MRS., MISS, MS., MR.., DR.

PATIENT NAME:_____BIRTH DATE:_____

SOCIAL SECURITY # :_____SEX:____GENERAL DENTIST_____

PERSON RESPONSIBLE FOR ACCOUNT:_____PHONE:_____

PATIENT ADDRESS:_____ CITY/ZIP:_____

PHONE:_____CELL:_____TEXT OK / NO

EMAIL:_____

PATIENT (or Parent) EMPLOYER:_____PHONE:_____
EMPLOYER ADDRESS:_____CITY:_____

SPOUSE EMPLOYER:_____PHONE:_____
EMPLOYER ADDRESS:_____CITY:_____

DENTAL INSURANCE INFORMATION-PRESENT YOUR CARDS

PRIMARY INS. CO. NAME:_____INSURED NAME:_____

ID #:_____ACCOUNT #:_____BIRTHDATE:_____

SECONDARY INS. CO. NAME:_____INSURED NAME:_____

ID#:_____ACCOUNT #:_____BIRTHDATE_____

MEDICAL INSURANCE INFORMATION-PRESENT YOUR CARDS

PRIMARY INS. CO. NAME:_____INSURED NAME:_____

ID #:_____ACCOUNT# :_____BIRTHDATE_____

SECONDARY INS. CO. NAME:_____INSURED NAME:_____

ID# :_____ACCOUNT#:_____BIRTHDATE:_____

ACCIDENT INFORMATION (IF APPLICABLE)

DATE OF ACCIDENT:_____WORKMANS COMP: YES / NO

WHERE& WHAT HAPPENED:_____

WHERE DO WE FILE CLAIMS:_____

WHO CAN WE CONFIRM WITH (AGENT NAME):_____PHONE #:_____
CLAIM NUMBER:_____

OFFICE FINANCIAL AGREEMENT

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, tests, office procedures, medications and also any other services not directly provided by the dentist.

INSURANCE:
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate 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 fees for service, it is your responsibility to have these 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.

PAYMENT:
FULL PAYMENT is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES** are due at the time of service, unless other arrangements are made. **Any ESTIMATE provided is a courtesy.** Final balances are provided **BY YOUR INSURANCE COMPANY** once your insurance claim has processed completely. If your insurance company has not paid the **FULL BALANCE within 30 days** from the original date of service, y**ou will have 15 days to pay the balance**. If your insurance pays more than your account balance, we will complete a refund to you in the form of original payment.

Please indicate below the form of payment you wish to choose. ***Please note that we do not accept cash or personal checks***

( ) Visa, MasterCard, Discover
( ) CareCredit

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named of the insurance benefits otherwise payable to me. The undersigned hereby guarantees all indebtedness incurred herein, and in the event this account is turned over for collection, shall be responsible for all costs incurred, including but not limited to responsible attorney fees.

The parties agree that in the event of a dispute over any payment or fee due to Indianapolis Endodontics, P.C by the undersigned, the Circuit Court or Superior Court of Marion County shall have exclusive jurisdiction and venue for any litigation filed by either party.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature:_____ **Date:**_____

Acknowledgement of Receipt of HIPAA Privacy Policies and Procedures

INDIANAPOLIS ENDODONTICS, P.C.

{NAME OF PRACTICE}

I, _____, have received and reviewed a copy of

INDIANAPOLIS ENDODONTICS, P.C. [PRACTICE'S] health information privacy and security policies and procedures.

Print Name _____

Signature _____

Date _____

Medications | Allergies | Conditions | More Conditions | BP/Weight/Physician/etc

NAME:

Today's Date:

Under a physician's Care: ☐

Physician's Name:

Emergency Contact: Name:
Phone:

Medications

Please list all medications and dosage if known including over the counter medications or herbal supplements.

Standard Medications

	Details		Details
☐ No Medications		☐ Birth Control Pills	
☐ Antibiotic		☐ Insulin	
☐ Pain Medicine		☐ Ulcer/Nexium	
☐ Heart Medicine		☐ Bone Related/Bisphosphor	
☐ Aspirin		☐ Antidepressants	
☐ Cortisone/Steriods		☐ Steroids	
☐ Blood Thinner		☐ Asthma/COPD	
☐ Blood Pressure		☐ Infectious	
☐ Hormone		☐ Seasonal	
☐ Thyroid		☐ Herbal supplements	

Specific Medications

Double Click to Select	for	
Double Click to Select	for	
Double Click to Select	for	
Double Click to Select	for	
Double Click to Select	for	

List of Medications

Medications | Allergies | Conditions | More Conditions | BP/Weight/Physician/etc

Allergies

	Reaction		Reaction
☐ Penicillin		☐ Food	
☐ Antibiotics		☐ Bleach	
☐ Aspirin		☐ Iodine/Seafood	
☐ Tylenol		☐ Seasonal	
☐ Sulfa		☐ Metal	
☐ Narcotics		☐ Sulfa	
☐ Local Anesth Novocaine/Li		☐ Seasonal	
☐ Latex		☐	
☐ Valium		☐	
☐ Nitrous Oxide		☐	

List of Allergies

Please check all that apply

Medications | Allergies | **Conditions** | More Conditions | BP/Weight/Physician/etc

Conditions

	Status		Status
☐ High Blood Pressure		☐ Heart Attack	
☐ Stroke		☐ Arrythmias	
☐ Pacemaker		☐ Rheumatic Fever	
☐ Heart Murmur		☐ Heart Valve Replacement	
☐ Artificial Joint		☐ Asthma	
☐ COPD		☐ Lung Disease	
☐ Cancer or Tumor		☐ Radiation/Chemotherapy	
☐ Kidney Disease		☐ Hepatitis or Liver Disease	
☐ Diabetes		☐ Thyroid Disease	
☐ Epilepsy or Seizures		☐ AIDS/HIV-positive	

General Notes

Medications | Allergies | Conditions | **More Conditions** | BP/Weight/Physician/etc

More Conditions

	Status		Status
☐ Arthritis		☐ Other Heart Disease	
☐ Ulcers/Digestive		☐ Bleeding disorder	
☐ Migraine/Headaches		☐ Anxiety	
☐ Fainting		☐ Tuberculosis	
☐ Glaucoma/Visual		☐ Systemic Lupus	
☐ Bisphosphonate meds		☐ Prosthetic Implant	
☐ Tobacco use		☐ Any Transplant	
☐ Alcoholism/Addiction		☐ Pregnancy/Nursing	
☐ Infectious Diseases		☐ TMJ/Jaw	
☐ Venereal Disease		☐ Excessive/Abnormal Bleedi	
☐ Psychiatric Care			
☐ Other			

Details

☐ Dental complications ☐ Other ☐ Facial Trauma

General Notes

RECORD OF DISCUSSION AND INFORMED CONSENT FOR CBCT

A CBCT scan---also called cone beam computerized tomography ---is an X-ray technique that is similar to medical CT scans. They produce images of your body that depict internal structures in cross section rather than the overlapping images typically produced by conventional X-ray exams.

A conventional X-ray of your mouth limits your dentist to a two dimensional (2D) view. Diagnosis and treatment planning can require a more complete understanding of a complex 3D anatomy. By way of example, a CBCT scan can provide significant 3D information which may be used by your treating dentist in assessing your condition, when planning for dental implants, surgical extractions, maxillofacial surgery, or advanced dental restorative procedures. CT scans are also useful in looking at and potentially diagnosing conditions which can be missed on a conventional x-ray. The CBCT scan can enhance your dentist's ability to see what he/she needs to see before treatment is started.

WOMEN:CBCT scans are NOT recommended for pregnant women because of danger to the fetus. Please Contact your OB-GYN before scheduling or agreeing to have this procedure if you are unsure of your pregnancy status.

RISKS: CBCT scans, like conventional X-rays, expose you to radiation. The dose is approximately the same as the following U.S. background radiation equivalents: 1 day for upper teeth, 3 days for lower front teeth and 5 days for lower back teeth. An alternative to a CBCT scan are conventional dental x-rays, however, they have the limitations previously noted.

While parts of your anatomy beyond your mouth and jaw may be seen on the scan, your dentist is not a physician or specialist to make assessments concerning your anatomy beyond your mouth or jaw. If the report raises a question as to something unusual outside the specific area of the mouth or jaw, your dentist may refer you to a physician for an evaluation. In such an event, our office can place the image on a CD. You should also understand that CBCT images do not show most soft tissues or fluids, so some problem areas may have to be imaged with other methods_____

I (the undersigned below) being 18 years or older, certify that I have read this consent form and that I understand the procedure to be performed, and its benefits, risks and alternatives. I acknowledge that I have had (or will have) a full opportunity to discuss this procedure with my referring/treating dentist at Indianapolis Endodontics P.C. or their designee, and have had any/all questions answered to my satisfaction.

Thus, I give my informed consent to Indianapolis Endodontics P.C. and their employees to perform the CBCT scan. I also acknowledge that Indianapolis Endodontics, P.C. sole responsibility is to perform the study; that I will not be examined Indianapolis Endodontics, P.C. or their employees, nor will they be reviewing the radiographic images that will be taken during the examination for diagnosis or treatment purposes. Instead, the scan will be reviewed by Indianapolis Endodontics, P.C., only to make certain that it is a satisfactory x-ray image for the referring doctor to use for diagnostic or treatment purposes prior to sending it to that doctor. The study will be interpreted by a qualified medical or dental radiologist; that the report of the study will be forwarded directly to my referring/treating dentist and that Indianapolis Endodontics, P.C., nor any of their employees will be involved in communicating the results of the report to me; interpreting the study or in providing counseling concerning the results of the study.

Therefore, I hereby release, acquit and forever discharge Indianapolis Endodontics,P.C. its employees, agents and representatives, from any and all claims, causes of action, damages, or judgments, whether in contract or in tort, for any injuries including personal that may be incurred arising out of or in any way connected to missed or lack of diagnosis or treatment, since I understand that Indianapolis Endodontics, P. C. are not my treating doctors.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT AND AGREE WITH WHAT IT SAYS

_____ _____

Patient signature Date