Family Dental Care
of Indiana, LLC

Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information. **Please Print.** All information will be kept confidential.

Today's Date: _____

First Name_____ M.I.____ Last Name_____
Male Female Birthdate_____ Age____ SSN:_____Email_____
Address_____City_____State____Zip_____
Phone _____ Other Phone _____ Have you been seen in our practice Y N
Referred By_____Has a family member been seen here Y N
Previous Dentist _____ Orthodontist _____ Medical Dr._____
Driver's Lic. #_____ Nearest relative not living with you_____Tel._____
Employer _____Work phone_____
If patient is a student, name of school/college_____
Person to contact in case of emergency_____Phone _____

Responsible Party

☐Self (skip this section) ☐Spouse ☐Father ☐Mother ☐Other _____
Name _____ SSN_____ Birthdate _____Age____
Phone _____Cell Phone_____ Email_____
Address_____City_____State____ Zip_____
Driver Lic #_____ Employer _____ Work Phone #_____
Is this person currently a patient at our office? Yes No

Spouse or other Guarantor Information (If different from above)

First_____ Last_____ Relation _____ SSN_____ DOB_____
Address_____City_____State____ Zip_____
Phone_____ Employer _____ Work Phone _____

Insurance Information

Student : ☐ full time ☐part time ☐not School Name and Address

_____

Marital Status: ☐married ☐divorced ☐widow ☐single ☐legally separated
Employed: ☐full time ☐part time ☐retired ☐not employed

Primary Insurance

Employer _____ Phone_____ Plan _____
Address _____City_____State _____ Zip_____
Insurance company _____ ID # _____ Phone _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Group #_____ Insured Name _____
Relation _____Birthdate_____ M F SSN_____Phone_____
Address_____ City _____State____ Zip_____

Secondary Insurance

Employer _____ Phone_____ Plan _____
Address _____City_____State _____ Zip_____
Insurance company _____ ID # _____ Phone _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Group #_____ Insured Name _____
Relation _____Birthdate_____ M F SSN_____Phone_____
Address_____ City _____State____ Zip_____

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature (Patient or guardian): _____ **Date:**_____

Authorization Form for Use or Disclosure of Patient Information (HIPPA)

Patient Name: _____

Patient's Date of Birth: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPPA Privacy regulations.

Specific description of the patient information to be used or disclosed (Check box below):

☐ Any and all health information unless otherwise specified

☐ Health information as specified below:

_____

The following person(s) may receive this patient information (Name and Relationship):

_____

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 4020 W. Goeller Blvd., Ste. A, Columbus, IN 47201. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature of Patient or Patient's Personal Representative:

_____ _____

(Signature) **(Date)**

If Personal Representative:

Print Name: _____

Signature: _____ Relationship to Patient: _____

Family Dental Care
of Indiana, LLC

Medical History

Patient Name _____ Preferred Name: _____
Date of Birth _____
Address _____
Phone Number _____ Mobile Number _____

Reason for today's office visit? _____

	Yes	No
1. Are you in good health?	☐	☐
2. Have there been any changes in your general health in the past year?	☐	☐
3. Are you under the care of a physician? Date of last visit _____	☐	☐
If so, for what are you being treated? _____		
4. Have you had any illness, operation or been hospitalized in the past 5 years?	☐	☐
If so, describe _____		
5. Do you have a prosthetic joint/implant? If so, where _____	☐	☐
6. Have you had a heart valve replacement or vascular graft?	☐	☐
7. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐

Have you had, or do you have:	Yes	No
Rheumatic Fever		
Damaged Heart Valves/Prolapse		
Heart Murmur		
High Blood Pressure		
Low Blood Pressure		
Chest Pain/angina		
Heart Attack		
Irregular heart beat		
Cardiac Pacemaker		
Heart Surgery		
Pneumonia, Bronchitis, Chronic cough		
Asthma		
Hay fever/sinus problems		
Snoring/sleep apnea		
Difficult breathing/other lung trouble		
Tuberculosis		
Emphysema		
Do you smoke? # of packs daily_____		
Do you use chewing tobacco		
Blood transfusion		
Blood disorder (anemia)		
Bruise easily		
Abnormal bleeding		
Hepatitis, jaundice, liver disease		
Infectious mononucleosis		
Gallbladder trouble		
Fainting spells		
Convulsions/ Epilepsy/ Seizures		
Stroke		
Thyroid trouble		

Have you had, or do you have:	Yes	No
Diabetes		
Low blood suger		
Kidney trouble		
High cholesterol		
Are you on dialysis		
Arthritis/joint disease		
Osteoporosis/osteopenia		
Osteonecrosis		
Stomach ulcers/acid reflux		
Contagious diseases		
Problems with immune system		
Delay in healing		
Tumor of growth		
Cancer/radiation/chemotherapy		
Chronic fatigue		
Are you on a diet		
History of alcohol abuse		
History of drug abuse		
Eye disease/glaucoma		
Mental health problems/ anxiety/depression		
Dental History		
Pain or clicking of jaws when eating		
Gums bleed while brushing or flossing		
Teeth are sensitive to hot or cold		
Teeth with sensitivity to sweets		
Pain with teeth		
Sores or lumps in or near mouth		
Head, neck or jaw injury		
Clench or grind your teeth		
Frequent headaches		
Orthodontic Treatment		

(OVER)

Medical History

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Are you currently taking:	Yes	No
Any medication, drug or pills		
Blood thinners (coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)		
Have you ever taken diet pills		
Any natural product, herbal supplement or homeopathic		
Are you taking or have you ever taken bone density medications or bisphosphonates (Fosamax, Boniva, Actonel, IV-Zometa or Aredia)		

Are you allergiec to or had a reaction to:	Yes	No
Local anesthetics (numbing medications)		
Penicillin		
Other antibiotics		
Sulfa Drugs		
Aspirin		
Amoxicillin		
Codeine		
Other medications		
Latex		
Do you have any known allergies		

Please list your current medications:

Medication	Dose	Frequency

Please list any other allergies:

Is there any health condition that the doctor should be aware of:

Do you wish to talk to the doctor privately? ☐Yes ☐No

Women Only:	**Yes**	**No**		**Yes**	**No**
Is there a possibility that you are pregnant?	☐	☐	Are you nursing?	☐	☐
Expected delivery date? _____			Are you taking birth Control?	☐	☐

Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding other methods of birth control.

I certify that I understand the above information and to the best of my knowledge the above questions have been answered. I understand that providing incorrect information can be dangerous to my health. I will not hold my doctor, or any other member of her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient, Parent or Guardian Date Reviewed by Date

I authorize my dentist and her team to perform a dental exam for the purpose of diagnosis and treatment panning. I authorize the taking of all x-rays required as a necessary part of this examination. Additionally I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and/or mobile phone concerning my appointments.

Signature of Patient, Parent/Guardian Date Witness Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient, Parent/Guardian Date

Financial Policy of Beth Ann Carter, DDS

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. Please understand that payment is considered part of your treatment. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

Payment is due at the time service is provided. Our office accepts cash, checks, MasterCard, Visa, Discover and Care Credit.

Please note: Returned check will be subject to additional fees.

If you have insurance:

- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay your deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, MasterCard, Visa, Discover or Care Credit at time we provide the service to you.
- Insurance payments are ordinarily received within 30-45 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected soon. If payment by your insurance company is not received within 60 days, or your claim is denied, you will be responsible for paying the full amount at that time.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors with Separated or Divorced Parents:
When two parents are each responsible for one half of the cost of the child's dental care, the Parent or Guardian who brings the child is responsible for the co-insurance or the full fee. They will also be responsible for collecting payment from the other parent.

For your convenience, we also offer automatic payments to your credit card as a form of payment. Please let us know if you would like to use this method of payment, as there is an additional authorization form to sign.
Thank you for the opportunity to serve your dental health care needs.

In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred, along with any charges associated with those agencies, and/or finance charges. I/we agree that in the event of default in payment, a reasonable collection agency fee of $75 will be applied to the delinquent balance and reasonable attorney fees, shall be added to the amount to the amount due on the account, plus any applicable court costs. By providing my cell number, I give prior express consent to receive calls from the creditor or its third-party debt collector at that number including calls and messages made by using an auto dialer or prerecorded message.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Patient Name (Print)	Signature of Guarantor	Date

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Family Dental Care
of Indiana, LLC
Beth Ann Carter, DDS

Cancellation Agreement

Here at Family Dental Care of Indiana, we value your time and commitment to choose us for your dental care. In doing so, we hope to establish a mutual respect for each other's time.

Therefore, our policy is as follows;

> Please schedule your appointments at a time that ***you*** are able to commit. We ask for your full commitment in being here when you say you can be here. We realize that things may come up which are out of your control that would make you have to change the appointment. If this happens, we ask you to call our office and explain to our Patient Benefit Coordinator why you need to change your appointment.
>
> If you ***fail*** to show up or ***cancel*** an appointment more than ***three*** times within one year we will unfortunately have to dismiss you from our practice. We will give you notice in writing.

Let's build a lasting relationship! We value and respect you as our patient and would like to be your dental practice family for a very long time!

Dr. Carter and her entire team are looking forward to a lasting relationship with you and your family. If you have any questions before your appointments, please feel free to give our office a call. We can be reached at 812-342-0766.

Patient Signature Date

4020 W. Goeller Blvd. Suite A Columbus, IN 47201 812.342.0766
Fax 812.342.242 familydentalcarein@att.net dentalcareindiana.com

COVID-19 Questionnaire

Patient Disclosure:
This patient disclosure form obtains information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A wear or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition, can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such condition with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature of patient (parent or guardian if minor) **Date**

COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-10 associated with receiving treatment during this pandemic. COVID-19 is highly contagious and has a long incubation period. You or hour healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental Procedures can create a fine water spray known as an aerosol which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

Patient Acknowledgement

I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office and unrelated to my visit here.

Signature of patient (parent or guardian if minor) **Date**