Welcome to Indy Dental Group™

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely.
If you have questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Today's Date_____

Patient Name_____
First Name (Legal) Last Name Middle Initial Preferred First Name

Birth date_____ Age_____ Sex □ M □ F Social Security _____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____ Email Address_____

□ Married □ Single □ Separated □ Divorced □ Widowed □ Partnered □ Minor □ Full Time College Student

Patient Employer (or School) _____ Patient Occupation_____

In case of an Emergency who should be notified? _____Relationship_____Phone_____

I found Indy Dental Group through:
□ Insurance □ Dental Provider □ Friend □ Family □ Web Site / Internet □ Telephone Directory □ Other

Whom should we thank for referring you? _____

***DENTAL - Primary Insurance*: □ YES □ NO**

Policy Holder (Subscriber) _____ Soc. Sec#_____Birthdate_____Relation to Patient_____
First Name Last Name Middle Initial

Insurance Company_____Employer_____

***DENTAL - Secondary Insurance*: □ YES □ NO**

Policy Holder (Subscriber) _____ Soc. Sec#_____Birthdate_____Relation to Patient_____
First Name Last Name Middle Initial

Insurance Company_____ Employer_____

***DENTAL Fee/ Discount Schedule*: □ YES □ NO** Name of Fee Program_____Phone_____Eligibility Date_____

Authorization

I certify that I, and/or my dependents, have the above insurance and assign directly to Indy Dental Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance claims. Indy Dental Group may use my health care information and may disclose such information to my Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize dental treatment for myself or my family member.

_____Date_____
Signature of Patient, Parent, or Legal Guardian

_____
Print Name Person Signing Relationship to Patient

_____Date_____
Signature of Patient, Parent, or Legal Guardian

_____

_____Date_____
Signature of Patient, Parent, or Legal Guardian

_____
Print Name Person Signing Relationship to Patient

_____Date_____
Signature of Patient, Parent, or Legal Guardian

_____

Dental History: Reason for Today's Visit_____

Date of last dental care_____ Date of last dental X-rays_____ Former Dentist_____

Check (√) if you have had any of the following:

□ Bad Breath	□ Grinding Teeth	□ Clenching	□ Sensitivity to Hot/Cold	□ Clicking/Popping Jaw	□ Loose or Broken Teeth
□ Bleeding Gums	□ Periodontal Disease or Treatment		□ Sensitivity to Sweets	□ Injuries to Mouth/Teeth/Head	□ Sores in Mouth or Lips
□ Orthodontic Treatment	□ History of Oral Cancer		□ Sensitivity when Biting	□ Food Collection between Teeth	□ TMJ Problems

MEDICAL HISTORY: Physician's Name _____Phone_____ Date of Last Visit_____

□ **YES** □ **NO** *Have you ever taken **"Antibiotic Pre-Medication"** prior to a dental appointment?

□ **YES** □ **NO** **Women: Are you Pregnant / or trying?** Due Date_____Breast Feeding_____

□ **YES** □ **NO** Are you currently taking blood thinner medication?

□ **YES** □ **NO** Are you currently under medical care? If YES, please describe_____

□ **YES** □ **NO** Have you had any serious illnesses or surgeries? If YES, please describe_____

□ **YES** □ **NO** Have you ever had a blood transfusion? If YES, please give approximate dates_____

□ **YES** □ **NO** Taking Birth Control Pills? **Antibiotics may interfere with effectiveness of oral contraceptives*

□ **YES** □ **NO** *Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen"?
(These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine).

□ **YES** □ **NO** *Have you ever taken Bisphosphonates (i.e. Fosamax, Boniva, Zometa/Reclast, Actonel, Aredia, Didronel, Skelid)?

□ **YES** □ **NO** *Do you **Smoke** or use smokeless tobacco? If YES, how many cigarettes (pipe, cigar) per day_____How many years_____

Check (√) if you now have or have ever had the following:

HEART / CIRCULATORY
- □ Heart Problems
- □ Heart Attack
- □ Heart Surgery
- □ Heart Stents
- □ Congestive Heart Failure
- □ Heart Murmur
- □ Pacemaker / Defibrillator
- □ Congenital Heart Problems
- □ Rheumatic Fever
- □ Mitral Valve Prolapse
- □ Artificial Heart Valves
- □ High □ Low Blood Pressure
- □ Fainting / Dizzy Spells
- □ Stroke

RESPIRATORY
- □ Asthma
- □ COPD
- □ Cough, Chronic, Persistent
- □ Coughing Up Blood
- □ Tuberculosis
- □ Emphysema
- □ Smoke Cigarettes □ Pipe □ Cigar

BLOOD DISORDERS
- □ Anemia
- □ Hemophilia
- □ Bruise Easily
- □ Petechia – "Pin" Size Bruising
- □ Sickle Cell Disease
- □ Taking/On Blood Thinner Medicine

ORTHOPEDICS / TRAUMA
- □ Artificial Joints □ Pre-medicate?
- □ Arthritis, Osteoporosis
- □ Arthritis, Rheumatoid
- □ Trauma - Teeth
- □ Trauma – Head/ Neck/ Face
- □ Cosmetic Surgery Face/Neck
- □ Cortisone Medicine / Treatment

INFECTIOUS
- □ Hepatitis □ Hep A □ Hep B □ Hep C
- □ AIDS □ HIV Positive
- □ Shingles
- □ Sexually Transmitted Disease
- □ Cold Sores
- □ MRSA (Methicillin Resistant STAPH Aureus)

OTHER
- □ please describe_____
- □ Diabetes □ Type I □ Type II
- □ Kidney Problems □ Renal Dialysis
- □ Thyroid Problems
- □ Ulcers □GERD □ Acid Reflux
- □ Sinus Problems
- □ Epilepsy □Seizures
- □ Glaucoma
- □ Alzheimer's Disease
- □ Cancer □Chemotherapy □Radiation
- □ Psychiatric Care
- □ Anxiety □Depression
- □ Alcohol □ Drug Addiction
- □ Recreational Drug Use

ALLERGIES: List All	**Current Medications: List All**
□ Latex □ Local Anesthetics □ Penicillin □ Sulfa □ Codeine □Other	

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect or outdated information can be dangerous to my health and safety. It is my responsibility to inform this dental practice of any/all changes in my medical and dental health history. I authorize the Dentist to perform any and all forms of treatment, medication, and therapy that may be required. I further authorize the Dentist to choose and employ assistance as needed.

_____Date_____
Signature of Patient, Parent, or Legal Guardian

_____
Print Name Person Signing Relationship to Patient

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Indy Dental Group
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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to Protected Health Information - "PHI", and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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 us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Appointment and Patient Reminders. We may ask that you sign-in on the day of your appointment at the front desk. We may use and disclose dental information to contact you as a reminder that you have an appointment or are due to receive care from this Practice. This contact may be by phone, email, in writing, text messaging, or otherwise which could (potentially) be received or intercepted by others.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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

Other Permitted and Required Uses and Disclosures. We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Fundraising. We do not fundraise. We do not sell or market your PHI.

Other Uses and Disclosures of PHI. Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights.

Access. You have the right to get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will charge you a reasonable administrative cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law. Access / copies may take up to 21 days to deliver after receiving your request in writing.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will try to accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Notice. You may receive a paper copy of this Notice upon request.

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 if 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.

Our Privacy Official: Nancy Locke
Telephone: 317-571-1900 Fax: 317-569-9695
Address: 12720 Meeting House Road
Carmel, IN 46032
E-mail: info@indydentalgroup.com