Please bring your completed forms with you to your appointment, or email them to smile@EnjoyIndyDental.com

ENJOY DENTAL LLC

PATIENT REGISTRATION FORM

Patient's Name:	Preferred Pronoun:	Today's Date:

Birth date: Gender: M F Non-binary	SSN: - -	Primary Phone #	Alt Phone #

Home Address:	City:	State:	Zip Code:

Referred By:	Preferred Time For Appointment:	Occupation:

Email Address:	Is it ok to Text You?	

If a Minor, Name Address & Phone of Guardian:

Person Responsible for Fee (if different):	DOB	Address (If Different):	Phone #:

Other family members seen here:

FOR OUR PATIENTS WITH INSURANCE

If hoping to utilize Dental Insurance Coverage, please make Insurance Card available

Primary Insurance Company & Policy #: Group#

Insured Person's Name:	SSN: - -	DOB: / /	Address:	Phone:	Employer:

Relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Work phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Enjoy Indy Dental or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Enjoy Dental LLC

Medical/Dental History

INSTRUCTIONS

"I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answer them to the best of my ability. I have been informed that if I am uncertain about the question or how the question related to my health status, I must discuss the problem with the doctor or a member of the office staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released without my express permission."

Patient's Initials_____ Dentist's Initials_____

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

All Information you supply to the office on this form, and the subsequent interview by the dentist and information received from your physician or any other source, will be held in the strictest confidence and will not be disclosed without your express and written permission.

1. Name, address & phone # of your physician:_____
2. Date of last visit to your doctor_____Purpose of visit: _____
3. Would you like to share information about any disabilities that may impact your dental care?_____If yes, describe:_____
4. Do you take illegal drugs?____If yes, what drugs, and when taken? _____

   Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.
5. Do you have AIDS, or are you HIV-positive? _____If yes, describe and provide current status:_____

   _____

   Have you ever had, or do you now have hepatitis?__If yes, describe.____
6. For females: Are you pregnant?_If yes, when are you due?_____
7. For females: Are you taking birth control pills?_____

   Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.
8. List all medications you are now taking or have taken previously on a regular basis, describe the strength and purpose for each.

   _____

   _____

   Note: There are many drugs and medications when mixed with other drugs and/or medications may cause complications, some of which may result in dangerous health problems. Information about your current use of drugs and medications is essential.
9. Have you ever had an allergic reaction to medication?_____If yes, describe:_____

   _____
10. Have you lost weight recently?__If yes, describe:_____

Have You Ever Had *or* Been Treated For:

11. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?_____
12. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats?_____
13. Stomach or intestinal disease?_____
14. Abnormal blood pressure, excessive bleeding, or anemia?_____
15. Breathing problems, asthma, tuberculosis, or hayfever?_____
16. Cancer, X-ray treatments, chemotherapy, or IV bisphosphonate (i.e. Zometa or Aredia) treatment?_____
17. Diabetes?_____
18. Kidney problems or renal dialysis? _____
19. A stroke, convulsions, or fainting spells?_____
20. Tumors or growths?_____
21. Arthritis or rheumatism? _____
22. Have you ever had a major operation?_____If yes, describe._____
23. Are you on a special diet?_____If yes, for what reason and describe:_____
24. Do you smoke?_____If yes, describe type and quantity:_____
25. Are there any other problems about your health of which you are aware?_____
26. For children under 10 years old: Was the child born by Cesarean Section?_____

27. Females: Are you currently taking any bisphosphonate medication? _____
28. Have you had any prosthetic joint replacement? _____
29. Are you allergic to latex? _____
30. Do you ever notice that your feet and/or ankles are swollen?
31. Are you aware of any swollen glands in your neck? _____

Dental History

1. Name of previous dentist _____ Date of your last visit: _____
2. Reason for your last visit (or series of visits) _____
3. Do you have any of your X-rays or dental records? _____
4. Chief dental complaint if any?

In respect to any previous dental treatment have you:

5. Ever fainted? _____
6. Had an allergic reaction? _____
7. Had abnormal bleeding? _____
8. Any other complications during or following dental treatment? _____ If yes, describe: _____

_____

9. Do your gums bleed from brushing or eating? _____
10. Does food catch between your teeth? _____
11. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? _____
12. Are any of your teeth sensitive to heat, cold, or pressure? _____
13. Do you grind your teeth or clench your jaws? _____
14. Do you have pain or clicking in the jaw joint in front of your ear? _____
15. Have your jaw muscles ever been sore? _____ If yes, describe: _____
16. Are there any sores or growths in your mouth? _____
17. Do any of your teeth ache? _____
18. Do you have any other dental complaint? _____

Person completing the form: _____ *Signature* _____

Print Name _____

If other than patient, indicate relationship: _____ *Date:* _____

Dentist's History Review & Significant Findings:

_____

_____

_____

_____

_____

_____

_____

_____

Signature: Dr. _____ Date: _____

ENJOY DENTAL LLC

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA.) I understand that in signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment, including direct or indirect treatment provided by my other healthcare providers also involved in my treatment.
- Payment obtainment from third party payers (i.e. – my insurance company.)
- Day-to-day healthcare operations of this practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices. It contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time, and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these request restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____

Patient signature ***date***

Jennifer Mohler DDS
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