PATIENT REGISTRATION

Welcome to South Circle Dental Care! Please complete the following medical history, dental history, and insurance information form as accurately and completely as possible, so that we may provide you the best possible care.

First Name:_____ M.I.:___ Last Name:_____ Date of Birth:_____

Address:_____ How long at this address_____

Previous Address (if less than 3 years):_____

Cell Phone:_____ Home Phone (if different):_____ Email:_____

Preferred Phone: Cell / Home / Work / Other Preferred Appointment Reminder: Text / Call / Email

Social Security #:_____ Gender: M / F Marital Status:_____ Maiden Name:_____

Spouse Name:_____ Date of Birth:_____ Spouse Social Security #:_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

Do you have immediate family members who have been seen in our office?_____

How did you hear about our office?_____

If referred, whom may we thank?_____

Employer Name:_____ Business Phone:_____

Business Address:_____ Work Phone:_____

Primary Dental Insurance Carrier

Insured's Name:_____ Insurance Co._____

Insured's Employer:_____ Insured's Date of Birth:_____

Insured's Social Security #:_____

Secondary Dental Insurance Carrier

Insured's Name:_____ Insurance Co._____

Insured's Employer:_____ Insured's Date of Birth:_____

Insured's Social Security #:_____

Patient Name:_____ Date of Birth:_____

What is the reason for your visit today?_____

If in pain, how would you rank your pain from 1 – 10? (1 being mild, 10 being severe) _____

How long have you been in pain?_____ How have you been managing pain?_____

Do any of the following worsen pain: Cold / Hot / Sweets / Pressure / Chewing / Other:_____

When was your last dental visit?_____ What treatment was done?_____

When was your last dental cleaning?_____ When did you last have X-rays?_____

How often do you brush your teeth?_____ How often do you floss your teeth?_____

Please check all of the following that apply to dental treatment you desire:

Check Up	
Cleaning	
Cavities Restored	
Teeth Pulled/Extracted	
Root Canal	
Missing Teeth Replaced	
Complete Dentures	
Implants	
Braces/Orthodontics	
Tooth Whitening	
Cosmetic Dentistry	
Mouth Guard	
Other:	

Are you happy with the appearance of your teeth and/or smile?_____

Please check all of the following that apply to your current or past dental history:

Have you ever had:		
	Braces/Orthodontic treatment	
	Teeth pulled/extracted	
	Root canal treatment	
	Implants	
	Crowns/Bridges/Fillings	
	Periodontal/Gum treatment	
	Mouth guard	
	Teeth ground or bite adjusted	
Do you experience:		
	Clenching/grinding of teeth when awake or asleep?	
	Popping/clicking or pain of jaw joint?	
	Tired jaws, especially in the morning?	
	Limited jaw opening?	
	Difficulty opening or closing?	
	Difficulty chewing on either side of the mouth?	
	Frequent headaches?	
	Bad breath or odor in the mouth?	
	Frequent cold sores, blisters, or other oral lesions?	
	Bleeding or sore gums?	
	Any teeth that feel loose?	
	Food frequently caught between teeth?	
	Gagging easily?	

Have you ever had an upsetting experience at the dentist? If yes, explain:_____

_____

Are you nervous about having dental treatment? If yes, explain:_____

_____

Patient Name:_____ Date of Birth:_____

Please check all of the following that apply to your current or past medical history:

Cardiovascular Disease / Heart Conditions, including:			**Endocrine / Hormone Conditions, including:**		
	Hypertension (high blood pressure)			Diabetes mellitus type I	
	Heart attack, chest pain (angina)			Diabetes mellitus type II	
	Heart failure			Hyperthyroidism	
	Swollen ankles, shortness of breath			Hypothyroidism	
	Coronary heart disease			Adrenal disorder	
	Atrial fibrillation, arrhythmia			Other:	
	Bypass surgery, other heart surgery				
	Stents				
	Artificial heart valves		**Renal Disease / Kidney or Urinary Conditions, including:**		
	Pacemaker, implantable defibrillator			Kidney disease, kidney failure	
	Congenital heart defect			Dialysis	
	High cholesterol			Frequent urination	
	Infective endocarditis			Urinary tract infection	
	Other:			BPH (enlarged prostate)	
				Other:	
Respiratory Disease / Lung Conditions, including:					
	Asthma		**Cancers or Tumors:**		
	COPD			Type:	
	Emphysema			Surgical removal	
	Bronchitis			Chemotherapy	
	Tuberculosis			Radiation therapy	
	Frequent sinus infections		**Neurological Disease / Nerve Problems, including:**		
	Seasonal allergies			Stroke, transient ischemic attack	
	Sleep apnea			Epilepsy, prone to seizures	
	Other:			Alzheimer's disease, dementia	
				Parkinson's disease	
Gastrointestinal / Digestion Disease, including:				Multiple sclerosis	
				Neuropathy (numb/tingling in limbs)	
	GERD, acid reflux, heartburn			Prone to fainting spells	
	Stomach ulcers			Other:	
	Celiac disease, gluten allergy				
	Crohn's disease				
	Irritable bowel syndrome		**Psychiatric Disease / Mental Health Disorder, including:**		
	Nausea, vomiting			ADD, ADHD (attention disorder)	
	Diarrhea, constipation			Depression	
	Liver disease, cirrhosis			Anxiety attacks, anxiety disorder	
	Other:			Bipolar disorder	
				Schizophrenia, personality disorder	
Muscle, Bone, or Joint Disorders, including:				Other:	
	Arthritis, rheumatoid arthritis				
	Osteoporosis		**Hematologic Disease / Blood Disorder, including:**		
	Muscle pain, muscle spasms			Anemia, sickle cell anemia	
	Fibromyalgia			Hemophilia (bleed easily)	
	Gout			Leukemia, lymphoma	
	Artificial hip, knee, other joint			Other:	
	Other:				
			Infectious Disease, including:		
Dermatological / Skin Disorders, including:				Hepatitis	
	Psoriasis, eczema			HIV/AIDS	
	Pemphigus, pemphigoid			Herpes	
	Lupus			STDs (sexually transmitted disease)	
	Other:			Other:	

Please list any other diseases or health conditions not mentioned above:

_____

_____

_____

Please list any recent major surgeries, emergency room visits, or hospitalizations:

_____

_____

_____

_____

Please list any known allergies, including food, latex, medications (penicillin, codeine), etc. and the reaction you have:

Please list all of the current medications you take and the dosage:

Medication	Dose

Please list any doctors/physicians/healthcare providers whose care you are currently under, and their phone number and address:

For women, are you pregnant, nursing, or likely to become pregnant? If yes, please describe below:

Do you use any tobacco products (cigarettes, chewing tobacco, e-cigarettes, etc.), alcohol, and/or recreational drugs (marijuana, methamphetamines, cocaine, heroin/opioids, etc.)? If yes, please list them below:

I, _____, attest that the above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of these forms. I agree to inform South Circle Dental Care of any and all changes to my medical history, surgical history, or medications at the next appointment without fail. The patient or responsible party shall be responsible for any attorney fees, collection agency fees, costs of collection, court costs, and other expenses or fees.

_____ _____

Patient or Parent/Guardian Signature Date

Contact Information for Protected Health Information

We at ***South Circle Dental Care*** strive to maintain the strictest confidentiality of your medical and financial information. Our team members are all aware that this information belongs to you, and you have the right to decide how it is used. Please take the time to review South Circle Dental Care's Notice of Patient Privacy Practices.

By my signing below, I, _____, acknowledge that I have had the opportunity to review and accept South Circle Dental Care's Notice of Patient Privacy Practices. I understand that a written copy is available upon my request. I understand that my dental, health, and insurance information may be disclosed to a referring dental office, such as an oral surgeon, orthodontist, etc. I also request that the following be permitted to the access and disclosure of my ***Protected Health Information***. Protected Health Information would include my name, diagnosis(es), test results, treatment, and dates of service. I understand that I may request at any time to have this list added to, taken away from, or otherwise altered.

You may disclose this information to the family members or non-family members listed below:

_____	_____	_____
Name	Phone Number	Relationship to Patient
_____	_____	_____
Name	Phone Number	Relationship to Patient
_____	_____	_____
Name	Phone Number	Relationship to Patient
_____	_____	_____
Name	Phone Number	Relationship to Patient
_____	_____	_____
Name	Phone Number	Relationship to Patient

_____ _____

Patient or Parent/Guardian Signature ***Date***

_____ _____

SCDC Team Signature Date

Notice of Patient Privacy Policy

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), South Circle Dental Care keeps medical and dental information and records confidential and will only use them for patient treatment, health care operations, and billing purposes.

TREATMENT: Our dentists, clinicians, and staff will use your medical and dental information to give you the best possible care.

HEALTH CARE OPERATION: SCDC will use this information for the appropriate follow-up care, patient notification, statistical and regulatory requirements, and internal quality assurance programs.

BILLING PURPOSES: SCDC will use your medical and dental information to bill the appropriate third party (ies) for your care.

DISCLOSURE OF INFORMATION UNDER EXTENUATING CIRCUMSTANCES

1. Health information will be given to family members in case of emergency or under other circumstances with proper authorization and documentation.
2. Health information may be given to other physicians or institutions under emergency situations.
3. Information may be given to proper authorities when neglect and/or abuse is alleged or suspected.
4. Information may be provided to courts or other agencies when a subpoena is given to this office.

PATIENT MEDIA RELEASE FORM

I _____ hereby authorize South Circle Dental Care or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publications, social media posts, etc.).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs, slides, or videos. If I wish to revoke this consent, I may do so in writing.

Please initial one option:

_____ I consent to have my photographs, slides, and videos used in any of the above stated situations.

_____ I only consent to have my teeth shown without any identifying features.

_____ I do not consent to have my photographs, slides, and videos used in any of the above stated situations.

_____
Patient or Parent/Guardian

_____
Witness

_____
Date

_____
Date

Authorization Signature on File and Financial Responsibility

Patient Name _____

- I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance benefits.
- I authorize the release and disclosure of my health care information relating to my dental claims.
- I hereby assign dental benefit payments from my insurance company to be paid directly to: **South Circle Dental Care**.
- If my insurance does not pay within 90 days, I authorize the office of **South Circle Dental Care** to charge interest on the outstanding balance of my account in the amount of 1.5% per month. If my account becomes delinquent and is turned over to an outside collection agency, I understand my account will be charged for all applicable collection, legal, and record duplication fees.
- The parent bringing the minor child for treatment is responsible for payment of services rendered. **South Circle Dental Care** will not intervene between custodial and non-custodial parents for the collection of money due.
- I understand **South Circle Dental Care** will not intervene in divorce cases. The responsible party listed will be responsible for the entire balance owed on the account for services rendered.

X_____ _____

Printed (Patient OR Parent/Guardian) Date

X_____ _____

Signed (Patient OR Parent/Guardian) Date

South Circle Dental Care
1030 E County Line Rd, Ste A-1
Indianapolis, IN 46227

Payment Policy

At South Circle Dental Care, we believe in pricing integrity and transparency, fully disclosing our costs for dental care, so that you can make an informed decision. We strive to estimate the cost of all treatment up front, so that you do not experience any "surprise fees" mid-treatment. We also generally increase our prices annually each January to stay consistent with inflation.

We realize that your smile is a big investment, and much like other big investments (a car, a house, etc.), dental care can be expensive. With this in mind, we have developed the following payment policies, so that – just like a loan for a car or a mortgage for a house – we can make dental care affordable and fair for everyone!

- We accept payment in the forms of cash, check, Visa, Mastercard, and Discover
- Payment is expected for services rendered that day. For patients without insurance, this will be the full fee. For patients with insurance, this will be the estimated co-pay.
- For multiple appointment procedures (such as crowns and dentures), the full payment will be divided up over the number of appointments for that procedure (2 appointments for crowns, 4 appointments for dentures).
- For patients without insurance who pay in-full at the time of diagnosis (during a hygiene or consult appointment), we are pleased to offer a 5% prepayment courtesy off your total fee!
- We are pleased to offer a 5% courtesy for our patients who are active or retired military without insurance. Thank you to our veterans for your service!
- For patients without insurance who are unable to make their payment at the time of service, we are pleased to offer the following payment options*:
    - In-house payment plan: Patient pays down payment of 25% or cost of lab fees (whichever is greater), followed by monthly payments. For treatment plans of $2,500 or less, payments are made over 6 months, interest free. For treatment plans of over $2,500, payments are made over 12 months, interest free. No credit check. Charged to credit card automatically each month. Ask us for more details.
    - If our payment plan is not affordable, we accept outside financing through Lending Point, CareCredit, GreenSky, and Ally, pending credit approval. Payments may be lower, but there are usually interest payments.
    - Smile Savers Club: Our in-house membership club, which offers savings on all treatment! For a flat fee each year ($450 for adults, $375 for children), membership entitles you to two cleanings, two exams, two fluoride treatments, and any necessary radiographs each year, and entitles you to 10% off all other additional treatment – no exceptions! Combined with our prepayment courtesy, you could save up to 15% off your treatment! Ask us for more details.

*May not combine in-house payment plan with outside financing

- For patients with insurance, we will file your claims for you. We will use your policy to estimate how much your insurance will cover, and how much your remaining portion (co-pay) will be. As stated above, we ask that you pay your co-pay at time of service. These estimates are not always accurate, and may be higher or lower than what your insurance actually covers. In the event that your co-pay is higher than estimated, you will receive a statement from us in the mail. In the event that your co-pay is lower than estimated, this will be credited towards your account for future treatment.
- For any treatment that is unsuccessful or that changes course mid-treatment (for example, a filling that changes to a crown, or an implant that changes to a bridge), any payments made toward original treatment will be credited towards your account for the new treatment.

Written Warranty

At South Circle Dental Care, we stand behind the care we provide. While we would love for our work to last a lifetime, we realize that this often isn't the case. Therefore, we have developed the following warranties for our work, based on the science behind the life of this work and on what is fair to you, our loyal patients. We have put these warranties in print for full transparency and to hold ourselves accountable if any treatment is unsuccessful.

- Fillings- 2 years, whether due to decay, chipping, or dissatisfaction with color; this warranty is voided if doctor recommended alternative treatment (such as a crown or extraction), or if patient lapses more than 12 months between hygiene appointments
- Crowns/Bridges- 1 year due to debonding, 2 years for decay or dissatisfaction with color, and lifetime for fracture; this warranty is voided if patient lapses more than 12 months between hygiene appointments
- Temporary Crowns- If patient has made an arrangement with doctor to wear a temporary crown until a permanent crown is affordable and have the cost of the temporary crown credited towards the permanent crown, the patient has 6 months to return for the permanent crown. Otherwise, this fee will not be applied to the permanent crown
- Implants- lifetime; this warranty is voided if patient lapses more than 12 months between hygiene appointments
- Dentures- 5 years, whether due to dissatisfaction with appearance, fit, or material failure; this warranty is voided if patient lapses more than 12 months between denture follow-up appointments
- Root Canals- 3 years; this warranty is voided if patient does not have tooth permanently restored within 60 days, or if patient lapses more than 12 months between hygiene appointments