MICHIANA FAMILY DENTAL 3575 Portage Ave, Ste # A, South Bend IN - 46628
(574) 347-3333 | www.michianafamilydental.com

PATIENT INFORMATION

NAME _____
(First) (Middle) (Last)

SOCIAL SECURITY # _____ DATE OF BIRTH _____

EMAIL ID _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER: _____ WORK PHONE _____ EXT _____

HOME PHONE _____ CELL PHONE _____

RELATIONSHIP TO INSURANCE SUBSCRIBER (The person in your family who your insurance is through): **Self** **Spouse** **Child** **Other**

PRIMARY DENTAL INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ SOCIAL SECURITY # _____
(First) (Middle) (Last)

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

DATE OF BIRTH _____ WORK PHONE _____ EXT _____

EMPLOYER _____ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

SECONDARY DENTAL INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ SOCIAL SECURITY # _____
(First) (Middle) (Last)

DATE OF BIRTH _____ WORK PHONE _____ EXT _____

EMPLOYER _____ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

HOW DID YOU HEAR ABOUT US: _____

CONSENT:

1. I hereby authorize Michiana Family Dental staff to take X-rays, photographs and any other diagnostic aids deemed appropriate by to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary.

2. I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Michiana Family Dental. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.

3. By signing below, **I certify that I read and write English and I have read, fully understand, and agree to the above items.**

Signature of Patient or Responsible Party: _____ ***Date:*** _____

(COMPLETE BOTH SIDES)

MICHIANA FAMILY DENTAL

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for is answering the following questions

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be Dangerous to my (or patient's) health. It my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Responsible Party: _____ ***Date:*** _____

MICHIANA FAMILY DENTAL

DENTAL HISTORY

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN- WHEN & WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED YES ☐ NO ☐

	YES	NO
Do your gums bleed while brushing or flossing	☐	☐
Are your teeth sensitive to hot or cold liquids/foods	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods	☐	☐
Do you feel pain to any of your teeth	☐	☐
Do you have any sores or lumps in or near your mouth	☐	☐
Have you had any head, neck, or jaw injuries	☐	☐
Have you experienced any of the following problems		
Clicking in your jaw	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing your jaw	☐	☐
Difficulty in chewing	☐	☐
Do you have frequent headaches	☐	☐
Do you clench or grind your teeth	☐	☐

	YES	NO
Do you bite your lips or cheeks frequently	☐	☐
Have you noticed any loosening of your teeth	☐	☐
Does food tend to become caught between your teeth	☐	☐
Have you ever had periodontal treatment (gums)	☐	☐
Have you ever worn a bite plate or other appliance	☐	☐
Have you had any difficult extractions in the past	☐	☐
Have you ever had any prolonged bleeding following Extractions	☐	☐
Do you wear dentures or partials	☐	☐
If yes, give the date they were placed _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

AUTHORIZATION AND RELEASE

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 INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

Signature of Patient or Responsible Party: _____ ***Date:*** _____

(COMPLETE BOTH SIDES)

MICHIANA FAMILY DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

_____
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

_____

_____

_____

Financial Policy

Thank you for choosing Michiana Family Dental as your dental provider. Our office is committed to providing you with the best possible care. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

Regarding Payment

We accept the following forms of payment: Cash, Check, Money Order, Voucher, Visa, Mastercard, Discover, American Express, and Care Credit. All returned checks will be subject to a $25.00 returned check fee. This fee covers the processing fees our office incurs.

Payment in full is due at the time services are rendered unless an agreement has been reached in writing between the office and the patient.

For major work (dentures, partials, crown, etc.), a 50% deposit is required to start the procedure and the remaining balance will be due upon delivery.

Regarding Insurance

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Pre-authorization from your insurance may be required before any work can be done to protect you from unexpected payment responsibilities. We make every effort to provide for you an accurate estimate with the information you and your insurance provides us. **Please be aware that your patient responsibility estimates are only an approximation and may change as we acquire more information from your insurance.** Insurance co-pays and deductibles must be paid at the time of service. **If for any reason your insurance does not pay its expected portion for a completed procedure, that balance will become the responsibility of the patient a statement of balance due will be generated and sent to you.** Please be aware that the process of insurance billing and auditing of patient account may occur sometime after you date of service. We always strive to ensure all insurance payment information and patient responsibilities are correct.

All invoices are due and payable within 30 days of service. Interest will be charged on past due invoices at the rate of 1.5% per month (18% per annum). In the event it becomes necessary to turn your account(s) over to a collection agency or use an attorney, the responsible party promises to pay, in addition to the amount due, all costs of collection, court costs, and reasonable attorney fees. The parties agree that the jurisdiction for any dispute under this contract be the County of St. Joseph.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

By signing below, I acknowledge that I have read and understand the Financial Policy as outlined in this document.

Signature of Patient or Responsible Party: _____ ***Date:*** _____

(COMPLETE BOTH SIDES)

MICHIANA FAMILY DENTAL

Definition of a "No-Show" Appointment

Michiana Family Dental defines a "No-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours' notice
- Arrives more than 10 minutes late and is consequently unable to be seen

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair (and frustrating) to other patients that would have taken the appointment slot
- Disrespects not only the provider's time, but also the time of the entire clinic staff

How to Avoid Getting a "No-Show"

1. Appointment Confirmation

   Michiana Family Dental will attempt to contact you one business days and two hours before your scheduled appointment to confirm your visit. If we are unable to speak with you and must leave a message, you will need to contact Michiana Family Dental before the appointment – otherwise the appointment will be canceled and marked as a "no-show".

2. Always Arrive 5-10 Minutes Early

   When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and/or to complete any necessary paperwork before the scheduled visit.

3. Give 24 Hours' Notice if You Need to Cancel

   When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of "No-Show" Appointments

If you miss 3 or more appointments within 90 days, you may be dismissed from the clinic.

1. Patient dismissal is at the discretion of your dental provider and the practice manager.
2. If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled.
3. Only emergency dental treatment will be offered within the first 30 days of dismissal.
4. Reapplication to the clinic after a six-month period after initial dismissal letter will be considered by your dental provider and the practice manager.

I have read and understood the Michiana Family Dental "No Show" Policy as described above.

Signature of Patient or Responsible Party: _____ *Date:*_____

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