Masters Family Dentistry

Patient Registration

Name: _____ DOB: __/__/____ Male: ___ Female: ___

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Check preferred contact option: Home ____ Work ____ Cell _____ Email ____

May we leave a message at your preferred number? Y N

Who shall we ask for when calling (i.e. parent's name)? _____

Address: _____ City: _____ Zip Code: _____

Social Security Number: ____-___- _____ Physician: _____ Phone: _____

How did you hear about us? _____

Would you like to receive appointment reminders in your email? Y N How about texted? Y N

Are you a full-time college student? _____ Name of school: _____

Emergency Contact: _____ Phone Number:_____

I give my permission for Masters Family Dentistry to discuss treatment, appointment dates/times, and account information with the following:

Name:	Relationship to Patient:
_____	_____
_____	_____

Responsible Party for payment: _____ Relationship: _____
Employer: _____ DOB: ___/___/___ SSN# ____-___-___
Insurance Coverage Information (if available, we would like a copy of the card as well):
Subscriber Name: _____ Name of Insurance Company: _____
Subscriber Address: _____ DOB: ___/___/___ Insured Phone: _____
Subscriber SSN: ____-___-___ Plan ID: _____
Relationship to Patient: _____ Insurance Company Phone Number: _____
Insurance Company Address: _____

_____ I certify that I do **NOT** have coverage under Medicaid or the Healthy Indiana Plan (HIP). If this changes it is my responsibility to let this office know of any changes.

I understand in signing this statement that I am financially responsible to Masters Family Dentistry for all fees incurred and all costs of collection: including but not limited to, if necessary, service, collection agency, and attorney fees. **If your insurance company does not pay your claim as expected, the responsible party is obligated for the balance of the account.** I hereby authorize the insured's insurance company to pay directly to Masters Family Dentistry for all services.

Signature: _____ Date: _____

Masters Family Dentistry

Medical History

Patient Name: _____ Birth Date: _____

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 answering the following questions.

Are you allergic to any of the following? ❑No Known Allergies
❑Aspirin ❑Penicillin ❑Codeine ❑Acyrlic ❑Metal ❑Latex ❑Local Anesthetics ❑Dyes ❑Tree Nuts
❑Other If yes, please explain: _____

Have you ever had any of the following? ❑Yes ❑No
❑Heart Surgery ❑Heart-Valve Replacement ❑ Artificial Joint/Joint Replacement Surgery ❑Heart Infection

Have you ever had Cancer? ❑Yes ❑No
If yes, please explain: _____
Did you receive any of the following?
❑Chemotherapy ❑Radiation ❑Bisphosphonate Treatment

Have you ever taken any of the following medications? ❑Yes ❑No
❑Blood Thinners ❑Aspirin ❑Bisphosphonates or Medications for Osteoporosis

Women: Are you
❑Pregnant/Trying to get Pregnant? ❑Nursing ❑Taking oral contraceptives?

Have you ever been hospitalized or had a major operation? ❑Yes ❑No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ❑Yes ❑No If yes, please explain: _____
(use back of sheet if needed) _____
Do you use tobacco? ❑Yes ❑No If yes, please explain: _____
Do you use controlled substances or illegal drugs? ❑Yes ❑No If yes, please explain: _____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

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 is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Guardian_____ DATE _____

Masters Family Dentistry
5170 Commerce Circle
Indianapolis, IN 46237
317-881-2500

Office Policy and Payment Agreement

This is an agreement between **Masters Family Dentistry**, as a creditor and the **Patient/Debtor** named on this form. Please take a few moments to review our office policies and inform us if you have any questions or concerns.

Payment

Payment is due at the time services are rendered. You may choose to pay via cash, check, credit card, or Care Credit. A $30.00 (thirty dollars) fee will be charged for a returned check.
If you have dental insurance, we will file **primary insurance only** for you (unless otherwise stated by your insurance contract). However, you will be responsible for any co-pay and/or deductibles on the day that the treatment is performed. Insurance is a contract between you and your insurance company. We are not a party to this contract. We bill your insurance company as a courtesy to you. Although we may **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and payments. If your insurance pays less than what we have expected you will receive a statement in the mail showing any charges to the account.
In the event that your account becomes delinquent by 60 days a finance charge of 1.5% may be applied to your account. Reasonable attorney fees, and other costs and charges necessary for the collection of any amount not paid when due, may also be charged.

Missed/Failed Appointments

Patients who do not show up for appointments or cancel within 24 hours' notice may be charged $35.00 (thirty-five dollars) per hour the appointment was scheduled for. This fee must be paid before you or any family member is seen in our office again. Possible dismissal from the practice would be the result of three failed appointments. If you are running more than 10 minutes late we may ask you to reschedule your appointment.

Safety and Infection Control

Dr. Masters and his staff strive to meet government regulations concerning infection control and the safety of our patients therefore we have a few guide lines that need to be followed.

- No food and/or drink are allowed beyond the reception area.
- **During Patient Treatment, ONLY the patient being treated is allowed in the operatory (one parent/guardian may accompany minor children.**
- Children under the age of 8 cannot be left unsupervised in the reception area.
- Cell phones and/or pagers are not to be left on in the operatories.
- Firearms and other weapons are prohibited in the office.

Patient Name: _____

Responsible Party: _____ Relationship: _____

Signature: _____ Date: _____
(Patient or Legal Guardian)

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5170 Commerce Circle
Indianapolis, IN 46237
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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed. Please review it carefully.

Our commitment here at Masters Family Dentistry is to serve our customers with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where the information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing service.
- When referring to a specialist for treatment/consultation.

We here at Masters Family Dentistry are committed to being all Federal, State, and Local Laws and regulations regarding Privacy Practices. If any other uses or disclosures that the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked.

I have read and understand the above Notice of Privacy Practices.

Patient Name: _____

Responsible Party: _____
(Patient or Legal Guardian)

Signature: _____ Date: _____
(Patient or Legal Guardian)

Masters Family Dentistry Missed Appointment Agreement

We value you as our patient and need your cooperation with keeping appointments so that we can provide your dental care. Missing or cancelling an appointment without proper notice means we are unable to fill this appointment time with another patient who desperately needs dental care.

Our policy requires:

- Appointment Confirmation: You must confirm your appointment through the automated text system or by calling our office. The office closes at 7pm on Mondays and 5:30pm on Tuesday through Thursday. It is your responsibility to confirm. If you do not confirm your appointment by the business day before then we reserve the right to give your appointment away to another patient. This will be considered a missed appointment.

  ☐ **Initials**

- Timely Cancellations: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. Cancellations made with less than 24 hours' notice will be considered a missed appointment.

  ☐ **Initials**

- On Time Arrivals: If you are more than 10 minutes late to your appointment, we reserve the right to give your appointment away to another patient. This will be considered a missed appointment.

  ☐ **Initials**

- Compliance: Patients are only allowed three missed appointments in a 12 month period. We will no longer be able to see you as a patient at our office if this occurs.

  ☐ **Initials**

Many patients use Masters Family Dentistry's services. Your help in keeping your appointments enables us to provide better and timelier care for all our patients. Thank you!

_____ _____

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

Form adapted from DentaQuest Institute - 2400 Computer Drive, Westborough, MA 01581