

Beautiful You Family Dental

Welcome to our practice! You'll be pleased you have selected Dr. Erin Coleman as your family dentist.

We're proud of the high standards we set for delivering the highest quality treatment. Our approach to client care begins with the thorough comprehensive examination you will experience today. As a result of today's visit you'll know far more about your dental condition and the range of treatment we can provide.

To ensure your investment in quality dentistry has long lasting benefits we build on a healthy foundation, your gums and the jaw structure supporting your teeth. Both areas must be free of disease before we begin. We won't take chances or compromise the final result by neglecting this first important step.

Our hygienists are especially trained to work with you to ensure we have the best possible environment to begin the treatment process. They will teach you home care techniques you must use to ensure your smile remains healthy.

We take our commitment to your smile seriously! You'll enjoy many years of great oral health as long as you continue to see us for regularly scheduled recare examinations. These visits allow us to spot any minor infection or disease early, while it is easily treatable.

If you have any questions at all, please call 317-875-7645 and we will be happy to give you any information you need.

Thank you for giving us the opportunity to put our years of training and experience to work for you!!

Sincerely,

Dr. Coleman and Team

Beautiful You Family Dental

Patient Information Form

Patient Information

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

Email Address: _____ Social Security #: _____ Date of Birth: _____

Home Address: _____ City: _____ Zip Code: _____

Spouse's Name: _____ Work Phone: _____

Nearest Relative not living with you: _____ Phone: _____

Physician: _____ Phone: _____

Pharmacy Name/Number: _____

Whom may we contact in case of an emergency? Name _____ Phone: _____

Whom may we thank for referring you to us? Name: _____ Phone: _____

Financial Information

Person responsible for the account: _____ DOB: _____

Address: _____ Phone Number: _____ SS #: _____

Insurance Company: _____ Name of the insured: _____

Insured SS#: _____ Employer: _____ Insured DOB: _____

Insurance ID#: _____ Insurance Phone: _____

Secondary Insurance Company: _____ Name of the insured: _____

Insured SS#: _____ Employer: _____ Insured DOB: _____

Insurance ID#: _____ Insurance Phone: _____

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information included in this packet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature

Date

Parent (if minor)

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 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 _____
- 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 Acrylic Metal Latex Local Anesthetics
- Other If yes, please explain: _____

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

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

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Financial Policy of Beautiful You Family Dental

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. Please understand that payment is considered part of your treatment. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and Care Credit.

Please note: Returned checks will be subject to additional fees.

If you have insurance:

- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, MasterCard, Visa or Care Credit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected soon. If payment by your insurance company is not received within 45 days, or your claim is denied, you will be responsible for paying the full amount at that time.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors with Separated or Divorced Parents:

When two parents are each responsible for one half of the cost of a child's dental care, the Parent or Guardian who brings the child is responsible for the co-insurance or the full fee. They will also be responsible for collecting payment from the other parent.

For your convenience, we also offer automatic payments to your credit card as a form of payment. Please let us know if you would like to use this method of payment, as there is an additional authorization form to sign. Thank you for the opportunity to serve your dental health care needs.

In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred, along with any charges associated with those agencies, and/or finance charges. I/we agree that in the event of default in payment, reasonable collection agency fees equal to fifty (50%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

Initials

date

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Patient Name

Signature of Guarantor, if Minor

Date

**HIPAA OMNIBUS RULE
 PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
 AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

 Please **print** name of Patient

 Please **sign** for Patient/Guardian of Patient

 Legal Representative/Guardian

 Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

- First Name Only Proper Sir Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
 (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email | |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- | | |
|--|--------------------------|
| It was emergency treatment | <input type="checkbox"/> |
| I could not communicate with the patient | <input type="checkbox"/> |
| The patient refused to sign | <input type="checkbox"/> |
| The patient was unable to sign because | <input type="checkbox"/> |
| Other (please describe) | <input type="checkbox"/> |

 Signature of Privacy Officer