

**PATIENT REGISTRATION**  
PLEASE COMPLETE THE FOLLOWING INFORMATION

DATE	LAST NAME	FIRST NAME	M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	
CIRCLE: MALE FEMALE		CIRCLE: SINGLE MARRIED SEPARATED DIVORCED WIDOWED	
AGE	BIRTHDATE	SOCIAL SECURITY NO.	
EMAIL ADDRESS			
WHOM MAY WE THANK FOR REFERING YOU TO OUR PRACTICE?			

**IF PATIENT IS YOUR CHILD:**

LAST NAME	FIRST NAME	M.I.
ADDRESS		
CITY	STATE	ZIP
CONTACT NAME AND NUMBER		
BIRTHDATE	AGE	CIRCLE : MALE OR FEMALE
SCHOOL	GRADE	
PERSON FINANCIALLY RESPONSIBLE FOR CHILD		

YOUR FORMER ADDRESS	CITY	STATE	ZIP
OCCUPATION AND COMPANY			
PERSON TO CONTACT FOR EMERGENCY		NUMBER	
ADDRESS		CITY	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		NUMBER	
ADDRESS	CITY	STATE	ZIP

**INSURANCE INFORMATION**

INSURANCE COMPANY	GROUP NUMBER
EMPLOYER NAME	
INSURED'S NAME	RELATIONSHIP TO PATIENT
INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NUMBER

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**Indigo Dental**  
**139 Executive Circle, Suite 101**  
**Daytona Beach, FL 32114**

I understand that, under the Health Insurance Portability & Accountability Act of 1996, ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

**Patient Name:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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**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 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 <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            | Radiation Treatments <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           | Recent Weight Loss <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      | Renal Dialysis <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                | Rheumatic 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   | Rheumatism <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      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <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        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <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          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <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 | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <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            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <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         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <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        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <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            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <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                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <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                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <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      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <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              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <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                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <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           |
|  |  |  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

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 \_\_\_\_\_

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)\_\_\_\_\_ dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of caring out my treatment, payment and health care operations. I understand that the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
6. In the event it is necessary, I agree to pay all associated fees on delinquent balances should the office use an outside source for collections.
7. We reserve the right to charge \$75 for appointments cancelled or broken without 24 hours advance notice. In addition, you may be required to "prepay" in order to schedule future appointments for treatment.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## Office Financial Policy

We realize that every person's financial situation is different. For this reason, we have worked very hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile.

### Dental Insurance

As a courtesy to you we are happy to file forms necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. Unless prior arrangements are made you will be expected to pay the percentage of your responsibility as services are performed. Please keep in mind that you have a maximum coverage per year and we can only estimate your portion, your insurance will not give us access to exact dollar amounts. We ask that you understand we neither work for the insurance companies, nor do we wish to. We work 100% for YOU. Our office does not diagnose, render treatment or establish fees according to any insurance tables or allowances. Office fees are based on care, skill and judgment of the professionals delivering the services, and by the cost of operating a dental office dedicated to excellence. If there is a dispute over your insurance we will provide information to support the necessity for treatment, which may assist you in recovering your benefit. If your insurance denies the claim or services, your account balance will become your responsibility.

### Payment Options

Cash/Check/Debit/Credit Card: For your convenience, we accept most major credit cards.

Payment Plan: For patients who desire a monthly payment plan, we have made arrangements with Care Credit, there are no application fees or down payments and can be arranged interest free. Applications are available from our office or you can apply online at [www.CareCredit.com](http://www.CareCredit.com).

It is our firm belief that all patients who come to our office want and deserve the best dental care that can be provided. Dr. Lloyd's goal is to provide excellent service at a fair fee. Payment is due at the time professional services are provided unless other financial arrangements have been made in advance with our office.

Please sign below to indicate that you understand our policies and wish for us to accept the assignment of benefits from your insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Dental Records Request Form

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Other family member(s) to transfer: \_\_\_\_\_

Previous Dentist/Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Please forward by email or mail a photocopy or digital copy of any dental treatment records, including current x-rays, photographs, and periodontal chartings to Indigo Dental Inc.

I hereby give permission for you to release any and all of my and/or family members dental records to Indigo Dental Inc.

\_\_\_\_\_  
**Patient Signature (parent if minor)**

\_\_\_\_\_  
**Date**

**For digital records, please email to:**

Info@MyDaytonaDentist.com

**Or Mail to:**

Indigo Dental Inc.  
139 Executive Circle, Ste. 101;  
Daytona Beach, FL 32114