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 SECURTY 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 SECURTIY 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 (upon request), 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.

Signature of Patient or Legal Representative: _____

Printed Name of Patient: _____

Legal Relationship to the Patient: _____

Date: _____

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below the name of the individual you authorize our office to discuss care with.

I give you permission to share my health information with:

Name: _____ Relationship: _____

Phone: _____

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 ◯ 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 _____

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.

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