11630 Olio Rd #100, Fishers, IN 46037
317-288-4226
info@vita-dental.com

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name____
Last First MI (Preferred)

Birthdate_______________ SS#___________________ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone________________ Wireless Phone__________________ Wireless Carrier________________

Email____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address____

Address 2____

City___________________________ State_______Zip__________________

Home Phone________________________

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name____________________________________Subscriber ID # ______________________

Insurance Company ______________________________________Phone____________________________

Employer__________________________Group Name_____________________Group #________________

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name____________________________________Subscriber ID # ______________________

Insurance Company ______________________________________Phone____________________________

Employer__________________________Group Name_____________________Group #________________

Comments:

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Medical History for New Patient

Last Name: ____________________ First Name: ____________________ Birthdate: ____________________
Name of Medical Doctor: __________________________________ City/State: ________________________
Emergency Contact: __________________ Phone: _____________ Relationship: ________________________

List all medications that you are now taking:

____ ____
____ ____
____ ____
____ ____
____ ____

Are you allergic to any of the following or list if not written?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever

Tobacco use? If so, what kind and how much? ____
Unusual reaction to dental injections? ____
Reason for today's visit ______________________________ Are you in pain? __________________
New patients:
Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? ______________
Do you have BiteWing x-rays that are less than 1 year old? ______________________________
Name of former dentist ______________________________ City/State ________________
Date of last cleaning and exam ____

☐ Patients over 18 allow a parent and/or legal guardian to provide medical/treatment information on their behalf.
Date: ____________________

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Notice of Privacy Policies

Last Name: ______________________ First Name: ______________________ Birthdate: __________________________

Date: ____________________________

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

I have read and understand the office's financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.