ArDente Dental, PSC

1009 S. Jackson Street, Frankfort, IN 46041

PATIENT INFORMATION…PLEASE PRINT

Last Name________________________________ **First Name**__________________________________

Mailing Address____

City__________________________ **State**________ **Zip**_________________

Marital Status: M S D W **Gender: Male Female**

Date of Birth ____/____/_______ **Age**_______ **School/Employer** ______________________________

Social Security Number____________________ **Driver's License Number**________________________

Home Phone_______________________ **Work Phone**_________________________________

Cell Phone_________________________ **E-mail Address**_______________________________

Preferred method of contact: Text Email Phone Call

Emergency Contact Outside of Immediate Family: Name________________________________

Phone Number_________________________ Relationship to Patient:___________________

PARENT/GUARDIAN (if a minor) or SPOUSE INFORMATION

Parent/Spouse Name: ___________________________________ Date of Birth: ______/______/__________

Address: ____

Social Security Number: _______________________ Driver's License Number: ______________________

Employer____

DENTAL INSURANCE INFORMATION

Primary Insurance: ___________________________ Subscriber:________________________________

Insurance is through: Self Spouse Mother Father Guardian Employer:________________________

Subscriber Identification Number:____

Secondary Insurance___________________________ Subscriber:_______________________________

Insurance is through: Self Spouse Mother Father Guardian Employer:__________________________

Subscriber Identification Number:____

How did you hear about our office? Billboard Phone Book Internet Search Insurance Company Mailing Advertisement Facebook Patient___________________________

Please list all other members of your immediate family who are patients in our office:

____.

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MEDICAL INFORMATION

Please circle any of the following which you have had or have currently:

Alcohol or Drug abuse	**Diabetes**	**Latex Allergy**
Anemia or Hemophilia	**Epilepsy or Seizures**	**Positive HIV Test or AIDS**
Arthritis	**Fainting or dizzy spells**	**Radiation Therapy**
Artificial Heart Valve/Joints	**Heart Murmur**	**Respiratory/Lung Disease**
Asthma	**Heart Problems**	**Rheumatic Fever**
Cancer or Tumor	**Hepatitis or Liver Disease**	**Sinus problems**
Chemotherapy	**High Blood Pressure**	**Surgery**
Cold Sores	**Kidney Disease**	**Thyroid Disease**

Other Medical Conditions (not listed above):____

____

Have you been under the care of a medical doctor during the past two years? **Yes** **No**
If yes, for what reason? ____

Medical Doctor's Name and Phone Number____

Are you currently taking any prescription or over-the-counter drugs? **YES** **NO** If yes, list drug and dosage below:

____

____

____

What medications are you allergic to?____

Have you ever been told you need to be pre-medicated prior to dental work? YES NO

Women Only:
Are you, or do you think you may be pregnant? Yes No
Due Date:________________________
Are you currently nursing an infant? Yes No
Do you use birth control medicine? Yes No
What type?______________________________

Tobacco Use:
Do you currently use a form of tobacco? Yes No
Circle all that apply:
Smoke Chewing Tobacco Snuff
How much per day?_______________________

Date:_______________ **Signature of patient or legal guardian:**________________________________

Office Use Only:
Medical History Reviewed:__________________________ BP:_______________________

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Dental Information

Ardente Dental strives to provide optimal oral health to our patients. Please complete the dental survey to the best of your knowledge to help us get to know you and your oral health.

Previous Dentist: ____

When was you last dental visit?____

What was the reason: ____

Are you having any dental problems at the time? YES/NO ____

Do your gums bleed when you brush? YES/NO

Do your gums bleed when you floss? YES/NO

Are you nervous to have dental treatment? YES/ NO

Have you had a bad dental experience at a dental office before? YES/NO

What would you change about your smile?

Replacing missing teeth	Yes	No
Bad Breath	Yes	No
Gum Disease	Yes	No
Appearance of Smile	Yes	No
Straighter Teeth	Yes	No
Whiter Teeth	Yes	No

Other: ______________________________

The information above is accurate and completed to be the best of my knowledge. I agree to inform the team of Ardente Dental, PSC of any changes in my medical condition. I also agree that no employee at Ardente Dental shall be held responsible for any error or omission that I may have made in the completion of my medical and dental information.

Sign: ____ **Date:** ________________________

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Office Policy Acknowledgement Form

I have received, read, and understood the ArDente Dental Office Policy Statement including the scheduling/failed appointments, insurance, collections, co-pays, and payment policies and I hereby agree to maintain those policies to the best of my ability. **Initials _______**

Payment Options (select the one that applies):

Self Pay- Cash, Check, Visa, Mastercard, Discover and Care Credit

Dental Insurance- I have provided my dental insurance information and agree to allow ArDente Dental to except assignment of benefit for payment. I understand all co-pays and deductibles are due at the time of service. I also understand I am responsible for all balances that are not covered by my insurance.

Payment options available

Collection Responsibility Notice Policy

In consideration of the services provided to the patient, I/we hereby guarantee payment in full of the patients account in accordance with the financial arrangements made at the time of discharge or, if no such arrangements are made, then payment shall be made in full within thirty (30) days of discharge. I/we agree that in the event of default in payment, reasonable costs of collection equal to fifty (50) percent of the delinquent balance, and/or reasonable attorney fees may be added to the amount due on the account balance. **Initials _______**

I have been informed of treatment that is recommended to myself or my dependent in which I am signing on their behalf. I have been informed of the risks, benefits, and alternatives of the treatment that is recommended. I understand a written treatment plan can be provided upon request and understand that I have the right to decline any treatment that has been recommended. I understand that by scheduling an appointment I am consenting to the treatment recommendations. I understand that the results of treatment are not guaranteed and that failures can occur for different reasons and that complications can occur with any given treatment. I agree to contact Dr. Jill Snyder if complications do occur in order for them to be addressed and treated accordingly . **Initials ______**

____
Printed Name

____
Dependents

____
Signature

____
Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

ArDente Dental, PSC

1009 S. Jackson Street, Frankfort, IN 46041

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I,____, have received a copy of this office's Notice of Privacy Practices.

____

Please print name

____

Dependent Children also covered

I authorize Ardente Dental to disclose my protected dental information to the following person(s):
1.____
2.____
3.____

____

Signature

____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

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