Fort Wayne Dental Group

7202 Engle road * Fort Wayne, Indiana 46804 * (260) 432-3459

PATIENT INFORMATION

DATE: _____

NAME: _____ ☐ Married ☐ Single ☐ Male ☐ Female
LAST FIRST M

ADDRESS: _____
STREET APT.# CITY STATE ZIP

BIRTHDATE: _____ TELEPHONE: _____ _____
MO DAY YEAR HOME# WORK#

SS# _____ CELL# _____ EMAIL _____

PLACE OF EMPLOYMENT: _____

Has any member of your family ever been treated in our office? ☐ YES ☐ NO

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE

	Primary	*Secondary*
Name of Insured		
Relationship to Patient		
Through What Employer		
Insurance Company / Group# / ID#		

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

NAME: _____ TELE# _____
LAST FIRST M

ADDRESS: _____
STREET CITY STATE ZIP

FAMILY INFORMATION

	HUSBAND (for adult patients) / **FATHER** (for pediatric patients)	**WIFE** (for adult patients) / **MOTHER** (for pediatric patients)
Name:		
Address:	LAST FIRST M	LAST FIRST M
Telephone#:	STREET CITY STATE ZIP	STREET CITY STATE ZIP
Birth Date / SS#:	HOME# WORK# CELL#	HOME WORK# CELL#
Employer:	MO DAY YEAR SS#	MO DAY YEAR SS#
	EMPLOYER	E MPLOYER

PERSON RESPONSIBLE FOR ACCOUNT

CHECK ONE:
☐ Patient ☐ Husband/Father ☐ Wife/Mother ☐ Guardian

** NOTE: Our office policy is that the parent authorizing treatment is responsible for child's account.

METHOD OF PAYMENT

Does Responsible Party currently have an account with this office? ☐ YES ☐ NO

Payment is due in full at each appointment unless prior arrangements have been made. If you have insurance, your co-pay is due at the time of service.

AUTHORIZATION

I authorize the release of any information relating to any incurred dental claims. I hereby authorize payment directly to Fort Wayne Dental Group of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and guarantee prompt payment. I hereby authorize Fort Wayne Dental Group to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and medical history are true and correct to the best of my knowledge. I agree to pay all monthly billing fees incurred in the event my bill becomes past due. I promise to pay any legal interest on this balance due, together with any collection costs and reasonable attorney fees incurred in effect collection of this amount.

SIGNATURE OF RESPONSIBLE PARTY

_____ DATE: _____

☐ Adult Patient ☐ Husband / Father ☐ Wife / Mother ☐ Guardian

PATIENT NAME: _____ **DATE:** _____
LAST FIRST M

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

PLEASE CIRCLE

Do you have a daily dental program? Describe: _____ YES NO
Do you have dental examinations on a routine basis? Last visit: _____ YES NO
Would you describe your present dental health as good? Comment? _____ YES NO
Do your gums ever bleed? Discuss: _____ YES NO
Do you feel nervous about having dental treatment? _____ YES NO
Have you ever had a bad experience? Describe: _____ YES NO
Do you want to replace missing teeth? _____ YES NO
Do you want to keep your remaining teeth? _____ YES NO
Do you have interest or questions regarding: ☐ Implants ☐ Sedation ☐ Invisalign ☐ Cosmetic Dentistry
Do you like your smile? Why? _____ YES NO
Name of previous dentists? (Optional) _____
Do you ever brux or grind your teeth? Discuss: _____ YES NO
Have you ever had orthodontic treatment (tooth straightening)? _____ YES NO
Are you interested in orthodontic treatment? _____ YES NO
Do you ever have clicking, popping or discomfort in the jaw joints (TMJD)? Discuss: _____ YES NO

MEDICAL HISTORY

Patient's medical doctor's name: _____
Are you under a doctor's care now? Why? _____ YES NO
Have you been hospitalized in the past two years? Why? _____ YES NO
Are you taking medications, pills, or drugs? What? _____ YES NO
Are you allergic to any medications or substance? What? _____ YES NO
Are you taking herbal supplements? _____ YES NO
Do you drink grapefruit juice? _____ YES NO
Are you pregnant? (women) _____ YES NO
Do you smoke? ☐ YES ☐ NO Are you interested in quitting? _____ YES NO
Do you drink pop/soda? ☐ YES ☐ NO Pop/Soda per day? (circle) 1 2 3 4 5 6 or more

Please **CIRCLE** if you have had any of the following:

Heart Trouble	Blood Disease	Excessive Thirst	Frequent Cough	Parathyroid Disease	Nervousness	Fever Blisters
High Blood Pressure	Bacterial Endocarditis	Artificial Joints/Hips	Lung Disease	X-ray Treatment	Hyperactivity	Herpes
Low Blood Pressure	Anemia	Kidney Trouble	Tuberculosis	Cobalt Treatment	Hyperglycemia	Bruise Easily
Heart Murmur	Chest Pain	Ulcers	Liver Disease	Chemotherapy/Radiation	Psychiatric Care	Sickle Cell Anemia
Rheumatic Fever	Shortness of Breath	Allergies	Hepatitis A (infec.)	Arthritis/Gout	Drug Addiction	Cerebral Palsy
Congenital Heart Lesion	Swelling of Feet/angles/Hands	Scarlet Fever	Hepatitis B (serum)	Rheumatism	Blood Transfusion	Cystic Fibrosis
Artificial Heart Valve	Fainting or Dizziness	Asthma	Yellow Jaundice	Pain in Jaw Joints	Hemophilia	HIV Positive
Heart Pacemaker	Stroke	Hay Fever	Learning Disabilities	Cortisone Medicine	AIDS	
Heart Surgery	Diabetes	Sinus Trouble	Cancer	Glaucoma	Venereal Disease	
		Emphysema	Thyroid Disease	Epilepsy or Seizures	Cold Sores	

Have you ever had any other serious illness not circled above? _____ YES NO
Please describe in detail: _____
Do you wish to talk to the doctor privately about any problem? _____ YES NO

X_____ DATE: _____
PATIENT SIGNATURE

How would you like to receive appointment Reminders?
☐ Email_____ ☐ Text _____ ☐ Phone_____

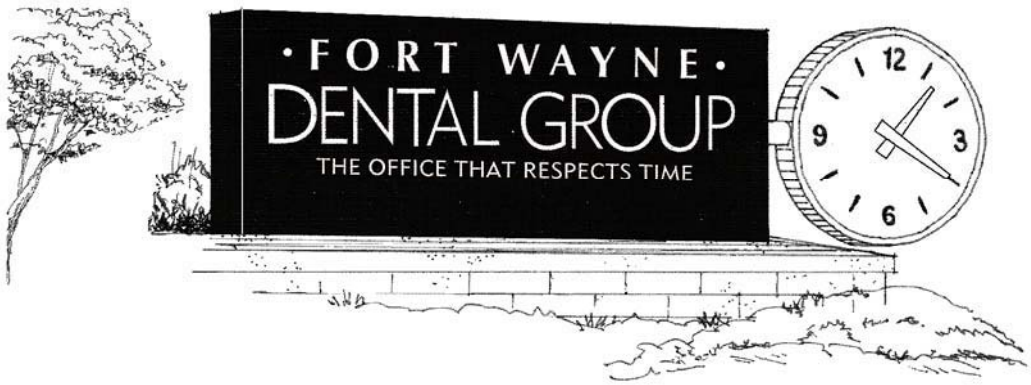
Reviewed by Doctor: _____ Date: _____ B.P._____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated_____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None ☐	_____	_____	DR._____
_____	_____	None ☐	_____	_____	DR._____
_____	_____	None ☐	_____	_____	DR._____
_____	_____	None ☐	_____	_____	DR._____

Rev. 7-2014



Brent E. Mutton, DDS
General Dentistry

Kevin B. Wright, DDS
Pediatric Dentistry

Matthew L. Creech, DDS
General Dentistry

The following is a statement of our Financial Policy.

PAYMENT AT THE TIME OF SERVICE: Payment is requested at the time services are rendered unless other arrangements have been made. Following is a list of potential areas of concern.

Insurance does not cover some or all of the treatment rendered. We gladly file your insurance claims as a courtesy to you. You are responsible for paying any deductibles, co-insurance amounts, and non-covered amounts at the time services are rendered unless prior arrangements have been made.

Extensive treatment. We recognize how important it is to work within a budget. Treatment plans are presented to the patient prior to work being done. The treatment plan outlines total cost, insurance estimated portion and patient portion that is due at the time of service unless prior arrangements have been made.

Divorce Cases. The parent that brings the child to the initial appointment and signs the new patient forms is the responsible party. Payment is due at the time of service unless prior arrangements have been made.

Financial arrangements are made at the time of treatment plan presentation. If you need to make financial arrangements prior to your appointment, please feel free to discuss it with any of the front office staff. Payment plans and outside financing are available for large treatment plans if arrangements are made in advance.

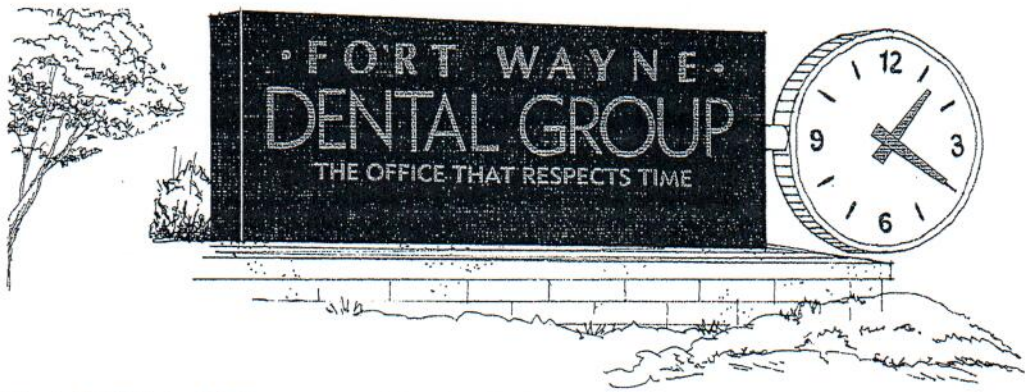
STATEMENTS: A billing statement will be sent to you each month. Any balance over 60 days will receive a monthly billing fee. Any account 90 days overdue will be referred to a collection agency.

We are here to serve you so please let us know if we can be of any help. If you have any questions, please feel free to contact us at any time. Thank you for choosing Fort Wayne Dental Group for your dental needs. Your signature acknowledges that payment will be made at time of service or financial arrangements will be made before treatment is rendered.

Signature: _____ Date: _____

7202 Engle Road * Fort Wayne, IN 46804 * Office: (260) 432-3459 * Fax: (260)436-4757
Email: fwdg@fortwaynedentalgroup.com * Website: www.fortwaynedentalgroup.com

Rev. 3-2011



Kevin B. Wright, DDS
Pediatric Dentistry

Matthew L. Creech, DDS
General Dentistry

Sarah J. Hagee, DDS
General Dentistry

Cancellation Policy/No Show Policy For Dental Cleanings and Procedures

1. Cancellation/No Show Policy for Dental Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

****If an appointment is not cancelled at least 24 hours in advance you will be charged a seventy-five dollar ($75) fee; this will not be covered by your insurance company.****

2. Scheduled Appointments

We understand that delays can happen, however we must try to keep the other patients and doctors on time.

****If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.****

Our goal is to provide quality individualized dental care in a timely manner. We appreciate our patients and their time. No-shows, late shows and short notice cancellations inconvenience those individuals who need access to dental care.

_____ _____ ___/___/___

Print Name Patient **Signature Patient/Guardian** **Date**

7202 Engle Road • Fort Wayne, IN 46804 • Office: (260) 432-3459 • Fax: (260)436-4757
Email: fwdg@fortwaynedentalgroup.com • Website: www.fortwaynedentalgroup.com

FORT WAYNE DENTAL GROUP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **03/23/2005**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $ 20.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: (260) 432-3459 Fax: (260) 436-4757

E-mail: fwdg@fortwaynedentalgroup.com

Address: 7202 Engle Road, Fort Wayne, IN 46804

Fort Wayne Dental Group
Patient HIPAA

I,_____have received a copy of this office's Notice of Privacy Practices.
Patient Printed Name

_____
Patient/Guardian Signature and Date

By Law, without your authorization, Fort Wayne Dental Group cannot communicate with:

1. Your Spouse
2. Your adult Children or Caregivers
3. Your Parents (if you are age 18 or over)
4. Your Grandparents

Fort Wayne Dental Group may need to communicate with your family or caregivers in the following circumstances:

1. Making appointments
2. Confirming appointments
3. Discussing treatment needed or performed
4. Account or Financial information

Please indicate below the names of people who we may communicate with regarding your appointment, dental treatment, or account information

☐ My Spouse_____

☐ My Adult Children_____

☐ My Parents_____

☐ My Caregiver_____

☐ Other_____

☐ I do not wish to allow any of my information to be shared with anyone including my spouse, or any other family member and or guardian.

I give Fort Wayne Dental Group my permission to forward any pertinent information with any Dental Specialty or Dental Group should I ever need a Referral, move, or need to change Dentists:

_____
Signature and Date

Form Rev 002
Rev Date: 8/30/2023

Fort Wayne Dental Group
Pediatric Patient HIPAA

I,_____have received a copy of this office's Notice of Privacy Practices.
Patient Printed Name

_____
Patient/Guardian Signature and Date

By Law, without your authorization, Fort Wayne Dental Group cannot communicate with:

1. Your Spouse
2. Your adult Children or Caregivers
3. Your Parents (if you are age 18 or over)
4. Your Grandparents

Fort Wayne Dental Group may need to communicate with your family or caregivers in the following circumstances:

1. Making appointments
2. Confirming appointments
3. Discussing treatment needed or performed
4. Account or Financial information

Please indicate below the names of people who we may communicate with regarding your appointment, dental treatment, or account information

☐ Mom/Dad_____

☐ Grandparents_____

☐ Aunt/Uncle_____

☐ My Caregiver_____

☐ Other_____

☐ I do not wish to allow any of my information to be shared with anyone including my spouse, or any other family member and or guardian.

I give Fort Wayne Dental Group my permission to forward any pertinent information with any Dental Specialty or Dental Group should I ever need a Referral, move, or need to change Dentists:

_____
Signature and Date

Form Rev 002
Rev Date: 8/30/2023