Patient Registration

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Patient Information

Address: _____ City, State:_____

Address 2: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Pager: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth: _____ Age: _____

Social Security Number: _____ Drivers License Number: _____

Email: _____ ☐ I would like to receive Correspondences via Email

Responsible Party (*If Patient is a Minor*)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ City, State:_____

Address 2: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____

Date of Birth: _____

Social Security Number: _____ Drivers License Number: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder

☐ Secondary Insurance Policy Holder

Emergency Contact

Emergency Contact: _____ Relationship to Patient: _____

Responsible Party's Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient Name: _____ Today's Date: _____

Is the Patient covered under dental insurance? ☐ Yes ☐ No

How will you be paying for today's visit? (Please Check One)

☐ Cash ☐ Check ☐ Credit Card ☐ Financing

Please read the following and sign below:

I understand that I am financially responsible for the total cost of treatment whether insurance pays or not. I understand that I am responsible to pay any unpaid balances within 30 days of the date of service if my insurance company fails to pay. I understand that I am responsible for paying any interest, collection fees, court costs and attorney fees if any account is referred to a third party collection agency. I understand that I will be charged and am responsible for paying for any appointments that are not cancelled more than 48 hours prior to the scheduled appointment time. I consent to be treated by Michael F. Tillery DDS, his associates, and staff.

_____ _____

Patient Signature/Responsible Party (If a Minor) Date

Michael F. Tillery, D.D.S.

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 _____
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 ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ 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	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

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 _____

3410 N. High School Road, Suite B
Indianapolis, IN 46224
(317) 291-8957

Please list all prescription medications, over the counter medications, and any vitamins/herbal supplements you are presently taking.

Medication	**Dosage**	**Times/Day**	**Condition Being Treated**
Example:			
Hydrochlorothiazide	200MG	2Xs/Day	High Blood Pressure

Name (Print): _____ **Signature:** _____ **Date:** _____

_____ No Changes _____ Changes Noted Above Signature _____ Date: _____
_____ No Changes _____ Changes Noted Above Signature _____ Date: _____
_____ No Changes _____ Changes Noted Above Signature _____ Date: _____
_____ No Changes _____ Changes Noted Above Signature _____ Date: _____

Tillery Family Dental
3410 N. High School Road, Suite B
Indianapolis, IN 46224
(317) 291-8957

ACKNOWLEDGMENT AND AUTHORITY

Name: _____ Date: _____

I consent to treatment as necessary or desirable for the patient named above, including but not restricted to drugs, medicine, performance of operations and conduct of laboratory, x-rays, or other studies that may be used by the attending Doctor, staff and qualified designate. I authorize Tillery Family Dental release any information to third party payers and/or health practitioners. I authorize and request my insurance company to pay Tillery Family Dental directly, otherwise payable to me. I understand my insurance carrier may pay less than the total bill for services and unconditionally agree to be responsible for and to pay for any and all charges incurred on my behalf or my dependents. I agree and understand that in the event I do not pay Tillery Family Dental the balance due and my account is placed in the hands of a collection agency and /or an Attorney for collection proceedings, I will be legally responsible for all Attorney/Collection fees, court costs, collection costs, consideration for assignment, litigation expenses, as well as any other incidental incurred by Tillery Family Dental and/or their assignees. I agree to pay Tillery Family Dental a minimum fee of $40.00 for any appointment I schedule and fail to arrive for or cancel with less than 24 hours advance notice unless a dire emergency dictates. The information I have given today is correct to the best of my knowledge. I also understand this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my personal and medical status. I authorize the dental personnel to perform any necessary dental services and I may need during diagnosis and treatment with my informed consent. If the patient is a minor certify I am the legal guardian.

_____ _____

Patient, Parent or Agent (Must Be 18 Years Older) Date

HIPPA AWARNESS

I authorize the professional office of my dentist named above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the follow terms and conditions:

1. Detailed description of the information to be released: to whom may the information be released [name(s) or class(es) of recipients]: The purpose(s) for the release (if the authorization initialed by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual): Expiration date or event relating to the individual or purpose for the release: is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorization, includes, as applicable: we will receive direct or indirect remuneration from third part for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name: _____Source of Authority: _____

TILLERY
FAMILY DENTAL
3410 N. High School Road, Suite B
Indianapolis, IN 46224
(317) 291-8957

Getting to Know You Better

Name: _____ Date: _____

How do you feel your overall oral health is? (Circle One)

Excellent Good Fair Poor

Do your gums bleed when you brush?.....Yes No

Is there any area in your mouth that is hurting you now?.....Yes No
If Yes, where? _____

Does Dentistry make you nervous?.....Yes No

Are you happy with the appearance of your teeth/gums/smile?.....Yes No

What don't you like about your smile? (Please Describe Below)
_____
_____

Would you like to discuss enhancing the appearance of your smile?.....Yes No

Would you like to discuss how to make your teeth "WHITE"?.....Yes No

Is there anything you would like us to take care of today for you?.....Yes No
If Yes, what? _____

New Patient Referral Form

Print Name: _____

Date: _____

How did you hear about our practice? Please check all that apply:

- Television
  - _____Fox 59 News
- _____ AT&T Yellow Pages
- _____ YP.com
- _____ Internet / Our Website (www.IndyFamilyDental.com)
  - If you chose "Internet/Our Website", what led you to our website?
    - Please Describe Below:
      - _____
- _____ Google
- _____ Social Media (Facebook, Google+, Twitter, YouTube)
- _____ Billboard at Crawfordsville Road and 465
- _____ Billboard at 38th Street and 465
- _____ Postcard – Tillery Family Dental Two-Sided Postcard
- _____ ValPak – Tillery Family Dental Coupon (Please Put Zip Code Below)
  - Zip Code: _____
- _____ Bus Stop Bench on the Corner of 34th and High School Road
- Sign (Check One of the Following)
  - _____ "New Patient Special" Sign
  - _____ Medicaid Dental Appointment Sign
  - _____ Family Dentistry Sign (Outside our front door)
  - _____ Sign on the Corner of 34th and High School Road
  - _____ "Open" Sign
- _____ You are an existing patient here at Tillery Family Dental
- _____ Referred by another Doctor's Office: _____
- _____ Tillery Family Dental Staff Member: _____
- _____ Referred by a patient/friend:
  - Indicate who referred you: _____