Craig E. Ball, DMD
Andrea L. Ball, DMD
Gary C. Ball, DMD
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North
2935 E. 96th Street, Suite 100
Indianapolis, IN 46240
317-846-3463

East
4130 E. 10th Street
Indianapolis, IN 46201
317-359-7244

Date: _____ **Reason for today's visit:** _____

Which location will you be visiting: 2935 E. 96th Street, Suite 100

PATIENT INFORMATION

Name:(First) _____ (Last) _____ (M.I.) _____ **Preferred name:** _____

Sex: ◯Male ◯Female Marital status: ◯Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed
Patient is: ◯You ◯Your Child

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

SS#: _____ **Birthday:** _____ **Age:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Employer: _____

Work Address: _____

City: _____ **State:** _____ **Zip:** _____

Occupation: _____ **How long:** _____

Best time to reach you: _____ **Where to reach you:** _____

Other family members seen by us: _____ **Whom may we thank for referring you?** _____

SPOUSE INFORMATION

His/Her Name: _____ **Employer:** _____

Cell Phone: _____ **SS#:** _____ **Birthday:** _____

RESPONSIBLE PARTY

Name: _____ **SS#:** _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer: _____ **Relationship to patient:** _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

City: _____ **State:** _____ **Zip:** _____

Insurance Co. Phone #: _____ **Group #**(Plan, Local, Policy #): _____

Insured's Name: _____ **Relationship:** _____

Insured's Employer: _____ **Insured's SS#:** _____ **Insured's Birthday:** _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

City: _____ **State:** _____ **Zip:** _____

Insurance Co. Phone #: _____ **Group #**(Plan, Local, Policy #): _____

Insured's Name: _____ **Relationship:** _____

Insured's employer: _____ **Insured's SS#:** _____ **Insured's Birthday:** _____

DENTAL HISTORY

How long since you have seen a dentist? _____ **Date of last completed dental exam:** _____

Do you currently have full or partial dentures? ◯Yes ◯No **If Yes, how old are they?** _____

Name of previous dentist: _____

City: _____ **State:** _____ **Zip:** _____

Please list your dental health goals: _____

CHILD HABIT HISTORY

(Please check Yes or No for each question)	Yes	No		Yes	No
Thumb / Finger sucking	◯	◯	Lip sucking / Biting	◯	◯
Nail biting	◯	◯	Nursing / Bottle habits	◯	◯

MEDICAL HISTORY

Patient's Name: _____

Are you currently under the care of a physician? ◯Yes ◯No **If Yes, please explain:** _____

Name of your physician: _____ **Physician's Phone #:** _____

Date of last physical exam: _____ **List outstanding findings of exam:** _____

Have you ever been hospitalized? ◯Yes ◯No **If Yes, list condition and date:** _____

Do you bleed excessively from cuts? ◯Yes ◯No **Do you smoke?** ◯Yes ◯No **Do you chew tobacco?** ◯Yes ◯No

Are you allergic to any medication? ◯Yes ◯No **If Yes, please list:** _____

Are you taking any prescription or any over-the-counter drugs? ◯ Yes ◯ No

If Yes, please list each one: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

(Please check Yes or No for each)	Yes	No		Yes	No
Heart attack / Stroke	◯	◯	Cancer / Chemotherapy / Radiation treatment	◯	◯
Heart murmur	◯	◯	Tumor / Malignancy	◯	◯
High blood pressure / Low blood pressure	◯	◯	Diabetes / Hypoglycemia	◯	◯
HIV+ / AIDS	◯	◯	Epilepsy / Seizures / Fainting spells	◯	◯
Artificial joint or heart valve	◯	◯	Hemophilia / Abnormal bleeding / Anemia	◯	◯
Mitral valve prolapse	◯	◯	Hepatitis / Kidney disease	◯	◯
Tuberculosis / Lung disease	◯	◯	Rheumatic fever / Rheumatic heart	◯	◯
Glaucoma / Eye disorder	◯	◯	Open heart surgery / Pacemaker / Bypass	◯	◯
Angina / Heart arrhythmia	◯	◯	Arthritis / Rheumatoid arthritis	◯	◯
Emotional disorder / Depression	◯	◯	Ulcer / Gastritis / Colitis	◯	◯
Asthma / Hay fever / Breathing difficulty	◯	◯	Ear or hearing disorder	◯	◯
Severe or frequent headaches	◯	◯	Congenital heart defect	◯	◯
Bacterial endocarditis	◯	◯	Endocrine disorder / Thyroid disorder	◯	◯
Arteriosclerosis / Aneurysm	◯	◯	Neurological diseases	◯	◯
Venereal disease	◯	◯	Drug or alcohol abuse	◯	◯

PLEASE LIST ANY OTHER MEDICAL CONDITION WHICH YOU HAVE OR HAVE HAD

_____

_____

FOR WOMEN ONLY

Are you pregnant? ◯Yes ◯No **If Yes, when is your due date?** _____

Are you nursing? ◯Yes ◯No **Are taking birth control pills?** ◯Yes ◯No

GENERAL & FINANCIAL CONSENT

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to proceed & perform any and all forms of treatments as explained to me, prescribe & administer medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that regardless of any dental insurance coverage I may have, I am ultimately responsible for payment of dental fees incurred. These fees are due and payable at the time the services are rendered unless prior arrangements have been made. The undersigned assumes and agrees to pay for all reasonable attorney fees (court costs) and other fees incurred while collecting the amount due.

Patient Signature: _____ **Date:** _____