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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: 4130 E. 10th Street ▼

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: _____

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:** _____