EDWIN ERRINGTON, DDS
SAVITHRI RAJU, DDS
Inverness Centre
7908 Carnegie Boulevard
Fort Wayne, IN 46804
[260] 423-2525

PATIENT INFORMATION (Confidential)

Name | Birth Date | Age | Soc. Sec. #

Address | City | State | Zip

Home Phone | Cell Phone

Check Appropriate: Minor Married Single Divorced Widowed Separated Male Female

Patient's Employer | Work Phone | Can you receive calls at work?

Business Address | City | State | Zip

Spouse or Parent's Name

Employer | Employer Phone

If Patient is a Student, Name of School or College | City/State

Whom may we thank for referring you?

Person to Contact in Case of Emergency | Phone | Relationship

RESPONSIBLE PARTY (for what insurance does not cover or any required co-pays)

Name of Person Responsible for this Account | Relationship to Patient

Address | Home Phone

Soc. Sec. # | Birth Date

Employer | Work Phone

DENTAL INSURANCE INFORMATION

Name of Insured | Relationship to Patient

Birth Date | Soc. Sec. #

Employer | Date Employed

Employer's Address | City/State | Zip

Insurance Company | Policy/Group #

Insurance Co. Address | City/State | Zip

Insurance Co. Phone | Amount of Your Deductible?

DO YOU HAVE ADDITIONAL (SECONDARY) DENTAL INSURANCE? If yes, complete below.

Name of Insured | Relationship to Patient

Birth Date | Soc. Sec. #

Employer | Date Employed

Employer's Address | City/State | Zip

Insurance Company | Policy/Group #

Insurance Co. Address | City/State | Zip

Insurance Co. Phone

OVER ⟶

- Is there anything about your teeth you would like to change? ☐ YES ☐ NO _____
- Are you interested in learning about bleaching or how you can have whiter teeth? ☐ YES ☐ NO

- Do you snore? ☐ YES ☐ NO
- Do you have high blood pressure? ☐ YES ☐ NO
- Has anyone reported that you choke or gasp for air while sleeping? ☐ YES ☐ NO
- Do you wake refreshed? ☐ YES ☐ NO
- Are you overly tired during the day? ☐ YES ☐ NO

PATIENT MEDICAL HISTORY (Confidential)

Medical Doctor: _____ Office Phone : _____ Date of Last Exam: _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness? If yes, please explain: _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? Please list: _____	☐	☐
4. Are you taking any blood thinners, aspirin or anticoagulants?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use alcohol? Other drugs?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Are you allergic or had any reaction to the following?	☐	☐
■ Local Anesthetics (e.g. Novocaine)	☐	☐
■ Codeine	☐	☐
■ Latex	☐	☐
■ Iodine	☐	☐
■ Aspirin	☐	☐
■ Other (please list) _____	☐	☐
9. For women only: Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

Do you have or have you ever had any of the following?	YES	NO
	☐	☐
■ High or low blood pressure	☐	☐
■ Heart disease or heart attack	☐	☐
■ Heart murmur	☐	☐
■ Mitral valve prolapse	☐	☐
■ Pacemaker, open heart surgery or heart valve replacement	☐	☐
■ Hip or joint replacement	☐	☐
■ Rheumatic fever	☐	☐
■ Hay fever/allergies	☐	☐
■ Asthma	☐	☐
■ Diabetes	☐	☐
■ Kidney problems	☐	☐
■ AIDS or HIV infection	☐	☐
■ Ulcer or stomach problems	☐	☐
■ Hepatitis or Jaundice	☐	☐
■ Epilepsy or nervous disorders	☐	☐
■ Bleeding or clotting disorders	☐	☐
■ Communicable disease (tuberculosis, herpes or venereal)	☐	☐
■ Thyroid problems	☐	☐
■ Leukemia or cancer	☐	☐
■ Liver problems	☐	☐
■ Do wounds heal slowly or present complications	☐	☐

List any other illnesses/medical conditions: _____

PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids?	☐	☐
3. Are your teeth sensitive to sweet or sour foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores/lumps in your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?	☐	☐
a) Clicking	☐	☐
b) Pain (joint, ear, side of face)	☐	☐
c) Difficulty in opening or closing	☐	☐
d) Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you had difficult extractions in the past?	☐	☐
12. Have you had prolonged bleeding after an extraction?	☐	☐
13. Have you ever had any orthodontic work?	☐	☐
14. Do you have any dental implants?	☐	☐
15. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
16. Have you ever had instruction on the care of your gums?	☐	☐

I certify that I have read and understand the above information, and that the above questions have been accurately answered. I authorize the dentist to release any necessary information to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist any insurance benefits.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, and any collection costs incurred due to non-payment of my account.

_____

Signature of Patient or Parent if minor

Date _____ Date _____

Date _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, have received a copy of TLC Dental LLC Notice of Privacy Practices. I understand the information I am providing is regarding myself, or if applicable the following minor: _____.

I will consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. This includes transfer of any records, personal information and/or discussion with any facility we do business with regarding your dental treatment, or account status.

I have the right to read the Notice of Privacy Practices before I decide to sign the consent below. And have been given or offered a copy of the Privacy Practices.

TLC Dental LLC reserves the right to change the privacy practices as described in the Notice of Privacy Practices. *If we change our privacy practices, we still issue a revised Notice of Privacy Practices, which contain the changes. Those changes may apply to any of your protected health information that we maintain.*

Please note that revocation of your consent must be in writing. Complaint form may be requested from our office.

May we leave detailed message on your answering machine at home?	*NA*	*YES*	*NO*
May we call you at work?	*NA*	*YES*	*NO*
May we leave a detailed message on your Voice Mail at work?	*NA*	*YES*	*NO*
If NO, may we leave a brief confirmation / reminder on your Voice Mail?	*NA*	*YES*	*NO*
May we leave a message with a secretary or coworker?	*NA*	YES	NO
May we contact you by email?	NA	YES	NO

If YES, Email Address to use_____

May we discuss your care and / or account with others in your household?	NA	YES	NO

If so, please list names of whom: _____

Signature _____ Date _____
(Signature of Parent or Guardian if Minor)

Financial Agreement Statement:

I agree to pay for all services rendered regardless of any insurance or other payer. In the event my account becomes delinquent, I agree to pay interest at 18%, court costs, and reasonable attorney fees in order to collect my account.

Signature_____ Date:_____
(Signature of Parent of Guardian if Minor)

I acknowledge that I have been informed there will be a $30.00 charge for all missed appointments.

PLEASE initial _____