Lindauer Family Dentistry

jennalindauerdds@gmail.com

5041 Bellemeade Ave. • Evansville, IN 47715 (812)477-1849

Medical History

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *PreMed
- ☐ Acid Reflux
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artifical Joint
- ☐ Blood Thinner
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Tumors
- ☐ *Pre-Med - Amox
- ☐ Allergies
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ aspirin
- ☐ Cancer
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ None
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Surgery
- ☐ Ulcers
- ☐ *PreMed - Clind
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Asthma
- ☐ Cigarette Smoker
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sleep Apnea
- ☐ Thyroid
- ☐ Veneral Disease
- ☐ *PreMed - Other
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ HIV
- ☐ Mental Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ SmokelessTobacco Use
- ☐ Tuberculosis

- ☐ Recent hospitalization for illness or injury
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Subject to frequent headaches
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously

FEMALES ONLY:

- ☐ Taking contraceptives
- ☐ Using Hormone Replacement Therapy
- ☐ Pregnant or planning pregnancy
- ☐ Nursing

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

Have you had an orthopedic total joint replacement (hip,knee,elbow,finger), if so, please describe below. Please include any complications from procedure:

_____

_____

Do you take antibiotic premedication for your dental visits? * ◯ Yes ◯ No

Pre med:

Name of your physician and your most recent physical exam:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Are you taking any medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

Do you have any allergies, (including allergies to medications)? If yes, please list below: * ◯ Yes ◯ No

Allergies:

Name and phone number of your preferred pharmacy: *

☐ *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

What is your immediate concern?

Dental Information

How would you rate the condition of your mouth?

*

◯ Excellent ◯ Good ◯ Fair ◯ Poor

I routinely see my dentist every:

◯ 3 Months ◯ 4 Months. ◯ 6 Months ◯ 12 Months

◯ I don't routinely see my dentist

Is there anything about the appearance of your smile that you would like to change?

_____

_____

Check all that apply: Had complications from past dental treatment

- ☐ Had trouble getting numb
- ☐ Had/have braces, orthodontic treatment
- ☐ Any teeth sensitive to hot, cold, biting, sweets
- ☐ Food gets trapped between any teeth
- ☐ Have you experienced popping and/or clicking of jaw joint
- ☐ You clench or grind your teeth
- ☐ Gums bleed when brushing or flossing
- ☐ Bone loss around your teeth
- ☐ Experienced gum recession
- ☐ Experienced a burning sensation in your mouth
- ☐ Had any reactions to local anesthetic
- ☐ You experience dry mouth
- ☐ Avoid brushing any part of your mouth
- ☐ Have you ever whitened or bleached your teeth
- ☐ You have difficulty chewing
- ☐ You wear or have worn a bite appliance
- ☐ Diagnosed and/or treated for gum disease
- ☐ Noticed an unpleasant taste or odor in mouth
- ☐ Teeth become loose on their own (without injury)
- ☐ You snore or wake up frequently during the night

Doctor or Hygienist Notes

_____

_____

_____

_____

_____

Response Date: ____/____/_____

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Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ ____-____
City State Zip Code

Please check all that apply:

☐ You may contact me at my home telephone number
☐ You may contact me on my mobile telephone number
☐ You may contact me on my work telephone number
☐ You may send me an email
☐ Other

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ ____-____
City State Zip Code

Responsible Party Information

This section only needs to be completed if the patient is under 18 years old.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians: (example: John Doe (212-555-1212)

_____

_____

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Name of the person completing this form: *

_____

_____

Relationship to the patient: * _____

_____

Response Date: ____/____/_____