Date _____

Account Information

Responsible Party _____ (Last, First, Middle)

Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐

Address _____ (Street, City, State, Zip) ( ) _____ (Area Code, Phone No.)

Cell Ph # ( ) _____ (area code) Pager # ( ) _____ (area code) E Mail _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____ Work Phone _____

Spouse Name _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____ Work Phone _____

Patient Information

Patient's Name _____ (Last, First, Middle)

Address (if same as above-write same) _____ (Street, City, State, Zip)

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____

Do you have dual coverage? Yes ☐ No ☐ If yes: _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

SIGNED PATIENT, OR PARENT IF MINOR _____ DATE _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED INSURED PERSON _____ DATE _____

Emergency Information

Name of nearest relative/close friend not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

Failure to pay accrued charges as they become due and owing may result in you being held responsible and liable for all reasonable collection fees and costs as well as reasonable legal fees and court costs incurred in collection. The patient understands that dental insurance is a contract between the insurance carrier and the patient and not between Badell Dental Clinic, PC and the insurance carrier. Therefore, the patient is personally responsible for all dental fees.

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ _____ _____ _____

MEDICAL HISTORY

Patient Name _____

General health (please check): Excellent ☐ Good ☐ Fair ☐ Poor ☐

Name & Address of physician _____ Date of last medical checkup _____

List all medication you are currently taking (prescribed or over the counter): _____

_____

_____ Birth Control Pills ☐Yes ☐No More Info On Back ☐

Have you ever been treated for or informed you have:

Heart Disease..... Yes☐ No☐	Tested positive H.I.V.. (Human Imuno-Virus) Yes☐ No☐	ChronicCough/Bronchitis..... Yes☐ No☐
Mitral Valve Prolapse..... Yes☐ No☐	VD. (Syphilis, Gonorrhea, Herpes)..... Yes☐ No☐	Asthma or hay fever..... Yes☐ No☐
Rheumatic fever..... Yes☐ No☐	Hepatitis..... Yes☐ No☐	Sinus trouble..... Yes☐ No☐
Heart Murmur..... Yes☐ No☐	AIDS. (Acquired Immune Deficiency Syndrome) Yes☐ No☐	Arthritis..... Yes☐ No☐
Have artificial heart valves.... Yes☐ No☐	Blood Transfusion..... Yes☐ No☐	Glaucoma..... Yes☐ No☐
Congenital heart lesions..... Yes☐ No☐	If YES, year performed _____	Ulcers..... Yes☐ No☐
Stroke..... Yes☐ No☐	Jaundice..... Yes☐ No☐	Tuberculosis..... Yes☐ No☐
High blood pressure..... Yes☐ No☐	Have Artificial Joints.. (Knee or Hip) Yes☐ No☐	Shunts/Other Conditions..... Yes☐ No☐
Low blood pressure..... Yes☐ No☐	Alcohol/Drug Abuse..... Yes☐ No☐	Organ Transplant..... Yes☐ No☐
Diabetes..... Yes☐ No☐	Cancer..... Yes☐ No☐	Serious Accident..... Yes☐ No☐
Epilepsy/Seizures..... Yes☐ No☐	If YES, year _____	If YES, explain injuries _____
Pacemaker..... Yes☐ No☐	Area(s) of body _____	_____

Have you been hospitalized in the last 5 years?.....Yes ☐ No ☐ If so, for what condition? _____

Are you allergic to: None ☐ Penicillin ☐ Codeine ☐ Local Injected Anesthetics ☐ Other Medications ☐
Latex ☐ Foods ☐ _____

Have you ever had radiation therapy?..... Yes☐ No☐

Are you subject to prolonged bleeding?..... Yes☐ No☐

Are you subject to fainting spells?..... Yes☐ No☐

(Women) Are you pregnant?..... ☐Yes ☐No How long? _____

Date of last dental visit? _____ Dentist's Name _____ City _____

Did you have X-rays taken?..... Yes☐ No☐

Have you had all your teeth X-rayed in the past 3 years?..... Yes☐ No☐

Do you wear full or partial removable dentures?... Yes ☐ No ☐ (If Yes) How old are they? _____

Do you clench or grind your teeth during the day or night?..... Yes☐ No☐

Does your jaw joint click? ..... Yes ☐ No☐ Do you have difficulty opening your mouth widely? Yes☐ No☐

Have you ever had pain in your jaw joint or your face (In and about your ears)?..... Yes☐ No☐

Do you have an unpleasant odor, or taste, in your mouth?..... Yes☐ No☐

Does food catch between your teeth?..... Yes☐ No☐

Do your gums bleed when brushing? . . . Yes ☐ No☐ Have you had gum disease or pyorrhea?..... Yes☐ No☐

Is your mouth or teeth sensitive to: . . .Pressure Yes☐ No☐ Cold Yes☐ No☐ Hot Yes☐ No☐ Sweet Yes☐No☐

Are you dissatisfied with the appearance of your teeth?..... Yes☐ No☐

Have you had orthodontic treatment (braces)?..... Yes☐ No☐

Are you afraid of any particular part(s) of dentistry? _____

_____

_____

Anything important about your physical condition the doctor should be aware of? _____

_____

_____

Patient's Signature _____ Date _____

Updates: _____

_____

_____

_____

_____

Badell Dental Clinic LLC
Gregory J Wittig

Authorization to Release protected Health Information (PHI) to designated Individuals

HIPPA laws prevent us from disclosing your PHI to family members, friends or other designated individuals, unless you provide Badell Dental Clinic LLC with authorization to release this information. We are required to have a completed authorization on file prior to releasing your PHI. This release will also allow Badell Dental Clinic LLC to leave messages concerning information related to time, dates, and Co-Pays of any upcoming appointments on phone numbers associated with family files.

Designation of Family members, Friends, or other individuals

Please designate individual(s) to whom we may release your PHI, including medical and billing records maintained by Badell Dental Clinic.

I, _____

Printed name (First name, Middle Initial, Last name) Date of Birth

Authorize Badell Dental Clinic LLC to disclose my PHI to the individuals listed below:

Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient

I understand that this Authorization is voluntary and I may revoke my authorization in writing at any time, except to the extent that action has been taken by Badell Dental Clinic LLC in reliance on this authorization. I understand that information used or disclosed pursuant to this Authorization may be subject to re-discloser by the individuals listed and no longer protected under federal law.

I also understand that by signing this form all prior Authorizations to Release Protected Health Information (PHI) to Designated Individuals are null and void as of my signature dated below.

Signature: _____

Signature of Patient or Legally Authorized Representative Date

Printed Name of Legally Authorized Representative (if applicable) _____

If representative, specify relationship to patient and attach legal documentation of your authority:
Legal Guardian____ Power of Attorney____ Other: _____

Badell Dental Clinic
P.O.Box 152
Knox, In 46534
574-772-3666

ACKOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICE

PURPOSE: This form is used to obtain acknowledgement of the receipt of our Privacy Practices or to document our good faith effort to obtain that acknowledgement.

X I,_____
Have received a copy of this Notice of Privacy Practices

X Signature_____

X Date_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Privacy Practices, but Acknowledgment could not be obtained because:

Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify)

_____
_____
_____
_____