Canal Dentistry
1960 Indianapolis Rd.
Crawfordsville, IN 47933
(765)364-1740

Welcome to our Office!
Patient Information (Confidential)

Name_____ Preferred Name_____
First Middle Last (Nickname)

Maiden Name_____ Any other last names we may have had for you?_____
Birthdate_____ SS#_____ Home Phone_____
Cell Phone_____ Email_____
Street Address_____
City_____ State_____ Zipcode_____
Check Appropriate Box: O Minor O Single O Married O Divorced O Widowed O Separated
Patient or Guardian's Employer_____ Work Phone_____
Spouse's Name_____ Employer_____ Work Phone_____
Person to Contact in Case of Emergency_____ Phone_____
Whom may we thank for Referring you?_____
When was your last dental visit?_____ What was it for?_____

Responsible Party Information (if other than self)

Name of Person Responsible for Account_____ Birthdate_____
Relationship to Patient_____ SS#_____ Driver's License#_____
Address_____ City_____ State_____ Zipcode_____
Phone_____ Email_____ Is this person a patient in our office? OYes ONo

Payment Information

For your convenience we offer the following methods of payment. Please check the option you prefer.

Payment in full is required at each appointment.

O Cash O Check O Visa O MasterCard O CareCredit O I wish to discuss office payment policy

Insurance Information

Name of Insured_____ Relationship to Patient_____
Birthdate_____ SS#_____ Date Employed_____
Name of Employer_____ Union or Local #_____ Work Phone_____
Insurance Company Name_____ Group#_____ Policy/ID#_____

Do you have Secondary Insurance? OYes ONo If yes, complete the following:

Name of Insured_____ Relationship to Patient_____
Birthdate_____ SS#_____ Date Employed_____
Name of Employer_____ Union or Local #_____ Work Phone_____
Insurance Company Name_____ Group#_____ Policy/ID#_____

Signature X_____ Date_____

Time 12:43 PM

CHAD CANAL DDS

[redacted]

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Canal Dentistry

Office Policies:
Thank you for choosing us as you Dental Health Care Provider. The following is a statement of our office policies. Please read carefully and sign prior to treatment.

Regarding Insurance:
We will file your insurance. However, you must pay your portion at the time services are rendered. It is your responsibility to see that your insurance has paid their portion in a timely fashion. Please notify us of any insurance changes. The contract is between you and your insurance company. We will do what we can to assist you, but it is ultimately your responsibility.

Account:
If for any reason your account is sent to a collection agency for collection, you will be responsible for any court and/or attorney fees. A fee of $50.00 will be charged for any returned checks.

Missed Appointments:
A fee will be charged for missed appointments or last minute cancellations. We request a 48 hour notice for any cancelled appointments. Please keep in mind we are closed on Friday's.

Please inform us if your address, telephone number, insurance policy, or any other pertinent information has changed since your last visit prior to your appointment.

I HAVE READ AND UNDERSTAND THE POLICIES LISTED ABOVE:

X_____ Date_____

Financial Responsibility Agreement

- By signing below, I guarantee that the information presented above is true and accurate. I give permission to Canal Dentistry to submit information to the insurance(s) that I have provided information to collect fees for services provided.

- I understand that I am responsible for all charges even those not paid by insurance. In the event payment is not made in a timely fashion I agree to pay all collections costs incurred by all parties such as court costs, actual reasonable attorney's fees and collection agency fees. My signature to this document may be used as a "signature on file" for the appropriate billing to a third party payer. By signing this I understand my co-pay is due when I am seen. This is an attempt to collect a debt and any information will be used for that purpose.

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

Purpose: This form, Notice of Privacy Practices, presents the information that the federal law requires us to give to our patients regarding our privacy practices. (Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws).

We must provide this notice to each patient beginning no later that the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the notice from the patient. We must also have the notice available at our office for patients to request to take with them. We must post the notice in our office in a clear, prominent location where it is reasonable to expect any patients seeking service from us to be able to read the notice. Whenever the notice is revised, we must make the notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the notice to each new patient at the time of service delivery and to any person requesting a notice. We must also post the revised notice in our office as discussed above.

I HAVE READ AND UNDERSTAND THE PRIVACY STATEMENT ABOVE:

X_____ Date_____