

# WELCOME

## ARLINGTON DENTAL GROUP

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We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

### Patient Information

Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_ Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_  
Notify in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_  
Referred By \_\_\_\_\_

### Telephone

Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Where do you prefer to receive calls? Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Email Address \_\_\_\_\_

### Responsible Party

Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
**Mailing Address** \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

### Insurance Information

#### **Primary**

Subscriber Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Patient ID# \_\_\_\_\_ Group# \_\_\_\_\_

#### **Secondary**

Subscriber Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Patient ID# \_\_\_\_\_ Group# \_\_\_\_\_

## Dental History (For New Patients Only)

Do you like your smile ? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, what would you change? \_\_\_\_\_

Do you now or have you ever experienced pain/discomfort in the jaw joint? (TMJ/TMD) Yes \_\_\_\_\_ No \_\_\_\_\_

Do you smoke or use smokeless tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_ Date Quit \_\_\_\_\_

Do you currently whiten your teeth? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, would you be interested in whitening? \_\_\_\_\_

Name of previous Dentist \_\_\_\_\_ Phone# \_\_\_\_\_

Date of last exam \_\_\_\_\_

Reason for leaving \_\_\_\_\_

## Medical Information

Physician's Name \_\_\_\_\_ Office Phone \_\_\_\_\_

Women Are you pregnant? \_\_\_\_\_ Do you take birth control? \_\_\_\_\_

### Check if you have any of the following conditions

- |   |  |
|---|--|
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Heart Problems                  |
| <input type="checkbox"/> Artificial Heart Valve   | <input type="checkbox"/> Hemophilia / Prolonged Bleeding |
| <input type="checkbox"/> Artificial Joints        | <input type="checkbox"/> HIV / AIDS                      |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Kidney Disease                  |
| <input type="checkbox"/> Abnormal Blood Pressure  | <input type="checkbox"/> Liver Disease (Hepatitis)       |
| <input type="checkbox"/> Cancer / Chemotherapy    | <input type="checkbox"/> Material Allergy (latex)        |
| <input type="checkbox"/> Chemical Dependency      | <input type="checkbox"/> Mitral Valve Prolapse           |
| <input type="checkbox"/> Circulatory Problems     | <input type="checkbox"/> Pacemaker / Heart Surgery       |
| <input type="checkbox"/> Cold Sores / Oral Herpes | <input type="checkbox"/> Respiratory Disease             |
| <input type="checkbox"/> Cortisone Treatment      | <input type="checkbox"/> Rheumatic Fever                 |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Tuberculosis                    |
| <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Ulcer                           |
| <input type="checkbox"/> Heart Murmur             |  |
| <input type="checkbox"/> Other _____              |  |

Allergies \_\_\_\_\_

Current Medications \_\_\_\_\_

Any other medical information \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have reviewed the information on this medical questionnaire and it is accurate to the best of my knowledge. I understand that this is information that will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ (For Update) Date \_\_\_\_\_

Patient Name \_\_\_\_\_

### **Insurance Authorization**

I authorize the insurance company, that I have indicated on the information form, to pay Arlington Dental Group any and all benefits that would otherwise be payable to me for services rendered. I also authorize the use of this signature on all insurance submissions.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Account Authorization**

I authorize Arlington Dental Group and staff to release all information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by my insurance. If my account should become delinquent, I will be responsible for all expences involved in collection effort, including but not limited to, attorney's fees, court costs, and collection fees.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Contact Authorization**

I authorize Arlington Dental Group to call me at all number(s) I have indicated on the information form in efforts to contact me. I may be contacted for reasons including but not limited to, reminder phone calls, appointment changes, collection efforts, and insurance inquiries.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Appointment Failure and Short Notice Cancel Notification**

I understand that if I fail to show up for an appointment my account will be charged a fee of \$35.00 for each appointment missed. I also understand that if I cancel an appointment without giving at least 24 hours notice my account will be charged a fee of \$25.00 for each appointment canceled.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*You may refuse to sign Appointment Failure And Short Cancel Notification, however, it is our office policy and DOES apply to you.

# Understanding My Insurance

Arlington Dental Group appreciates the confidence you have shown in choosing us to provide your dental care needs. The services you elect to receive, implies a financial responsibility on your part. The responsibility obligates you to ensure payments in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for your bill.

Many insurance companies have many stipulations that may affect your coverage. It is ultimately the patient's responsibility to know your coverage and benefits. As a service to you, every attempt will be made to determine your level of eligibility, covered services, amounts payable, co-payments, deductibles and plan maximums. Plan maximums are the total amount of benefits an insurance company will pay annually and in some cases for a lifetime. This determination will be based on the dental insurance information you have provided to us.

Any planned services over \$300.00 should be pre-determined. This is a process where the dentist submits a treatment plan to the payer/insurance company before the treatment begins. The payer/insurance company determines how the services will be covered. Upon a mutual financial agreement between the patient and the dentist, treatment may commence. Pre-determination is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered. Submission of additional claims, from our office or any other dental office; prior to the final payment of the pre-determined service, may affect the proposed payment.

Insurance benefits provided by an employer were negotiated via the employer and insurance company. Not all recommended dental services may be covered by your policy, but does not mean that it is not a dental necessity for good oral health. This being stated, there may be extenuating circumstances in which your coverage may go beyond the scope of your plan. For example: a dental accident, heart disease, diabetes, or pregnancy may warrant additional dental benefits.

Co-payment and deductibles are due at the time of service. If you are unable to render payment at the time of service, we can help you seek payment options through our financial payment program: *CARE CREDIT*, or reschedule your appointment for a better time.

If you have a specific question about your dental insurance, please contact your human resources or insurance company as listed on your dental policy.