PATIENT INFORMATION

DATE _____

NAME _____ ☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ MINOR
LAST FIRST M

ADDRESS _____
STREET CITY STATE ZIP

BIRTH DATE _____ E-MAIL ADDRESS _____
MONTH DAY YEAR

TELEPHONE _____
HOME WORK CELL PHONE

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____
Has any member of your family ever been treated in our office? ☐ YES ☐ NO
Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

FILL IN BOTH BLOCKS FOR MINOR CHILD,
FILL IN APPROPRIATE BLOCK FOR ADULT

FATHER/HUSBAND PATIENT HERE __YES __NO

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO SUBSCRIBER # GROUP #

MOTHER/WIFE PATIENT HERE __YES __NO

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTHDATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO SUBSCRIBER# GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

OUTSIDE OF IMMEDIATE FAMILY/HOUSEHOLD

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE# _____

PERSON RESPONSIBLE FOR ACCOUNT

PLEASE CHECK ONE

☐ PATIENT ☐ FATHER/HUSBAND
☐ GUARDIAN ☐ MOTHER/WIFE

METHOD OF PAYMENT

☐ PAYMENT IN FULL AT EACH APPOINTMENT (CASH/CHECK)
☐ PAYMENT IN FULL AT EACH APPOINTMENT (VISA/MC)
CARD# _____ EXP DATE _____
☐ I WISH TO DISCUSS THE DENTAL OFFICE'S FINANCIAL POLICY

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group Insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
☐ ADULT PATIENT ☐ FATHER/HUSBAND ☐ GUARDIAN ☐ MOTHER/WIFE

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a service & billing charge will be added to the account for current monthly billing period. The service charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

_____
DATE

DENTAL HISTORY

Patient Name

Patient Account No.

Medical Alert

STEVEN C. HOLLAR, DDS
CHARLES A. HOLLAR, DDS
ANDREA M. HUTTON, DDS
MATT S. CARMIEN, DDS
574-267-8466

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit_____**Last Dental Cleaning** _____ **Last Full Mouth X-rays**_____
What was done at your last dental visit? _____

Previous Dentist's Name _____
Address _____State_____Zip _____
Telephone_____

How often do you have dental examinations?_____
How often do you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No
If yes, please describe:

Are any of your teeth sensitive to:
Hot or cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No
If yes, where?

Do you:
Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Smoke/chew tobacco? Yes No

Have you ever had:
Orthodontic treatment? Yes No
Oral surgery? Yes No
Periodontal treatment? Yes No
Your teeth ground or the bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If so, please describe, including cause

Have you experienced:
Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty in opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No
Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern?

Have you ever had an upsetting dental experience? Yes No
If yes, please describe

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe _____

MEDICAL HISTORY

STEVEN C. HOLLAR, DDS
CHARLES A. HOLLAR, DDS
ANDREA M. HUTTON, DDS
MATT S. CARMIEN, DDS
574-267-8466

1. Have you been under the care of a medical doctor during the past 2 years?..... Yes No
   If yes, for what?_____
   Physician's Name Phone_____
   Address City State Zip_____
2. Have you taken any medication or drugs during the past 2 years?..... Yes No
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin?..... Yes No
   If yes, please list name and dosage_____
4. Have you ever taken prescription medications for weight loss (diet pills)?..... Yes No
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance?..... Yes No
   If yes, please list:)_____
6. Have you been a patient in the hospital during the past five years?..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surg., Disease, Attack)	Yes	No	Ulcers.....	Yes	No	Hepatitis A (infectious) B (serum)..	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	Veneral Disease.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems...	Yes	No	A.I.D.S.....	Yes	No
Heart Murmur.....	Yes	No	Glaucoma.....	Yes	No	H.I.V. Positive.....	Yes	No
High Blood Pressure.....	Yes	No	Contact Lenses.....	Yes	No	Cold Sore/Fever Blisters.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphysema.....	Yes	No	Blood Transfusion.....	Yes	No
Artificial Heart Valve.....	Yes	No	Chronic Cough.....	Yes	No	Hemophilia.....	Yes	No
Heart Pacemaker.....	Yes	No	Tuberculosis.....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Asthma.....	Yes	No	Bruise Easily.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Hay Fever.....	Yes	No	Liver Disease.....	Yes	No
Cortisone Medicine.....	Yes	No	Latex Sensitivity.....	Yes	No	Yellow Jaundice.....	Yes	No
Swollen Ankles.....	Yes	No	Allergies or Hives...	Yes	No	Neurological Disorders.....	Yes	No
Stroke.....	Yes	No	Sinus Trouble.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Diet (Special Restrictions)	Yes	No	Radiation Therapy..	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Artifical Joints (hip,knee,etc) ..	Yes	No	Chemotherapy.....	Yes	No	Nervous/Anxiety.....	Yes	No
Kidney Trouble.....	Yes	No	Tumors.....	Yes	No	Psychiatric/Psychological Care.....	Yes	No

8. Do you use more than 2 pillows to sleep?.....Yes No
9. Have you lost or gained more than 10 pounds in the past year?.....Yes No
10. Do you have or have you had any disease, condition, or problem not listed?.....Yes No
11. **Women:** Are you: **Pregnant:** Yes__Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature_____Date_____

History Review

Dentist Signature Date

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

AND

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Dr. Steven C. Hollar Address: 904 S. Union St. Warsaw, IN 46580.

www.DentalHealthpc.com Telephone: 574-267-8466 Fax: 574-267-8389

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations. I have reviewed a copy of this office's Notice of Privacy Practices.

Patient's Signature: _____ **Date**: _____

If this Consent is signed on behalf of the patient, complete the following:

Representative's Name: _____ **Relationship to Patient**:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

A COPY OF OUR PRIVACY PRACTICES IS AVAILABLE ON OUR WEBSITE.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement 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) _____