TODD WHITLOCK, DDS
3671 S. Sare Rd.
Bloomington, IN 47401
(812) 332-0052

Patient Information

Name _____ Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Other

Date of Birth _____ Age _____ SS# _____

Home Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone _____ Work Phone _____ Ext. _____

Cell Phone _____

Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Employer/School _____ Occupation _____

Employer Address _____

City _____ State _____ Zip _____

Person Responsible for Account _____ Phone _____

Billing Address _____

City _____ State _____ Zip _____

Spouse/Guardian's Name _____ Employer _____

Spouse/Guardian's Occupation _____ Work Phone _____

Please Share With Us...

How were you referred to our office?

☐ Family or Friend: _____ ☐ Drive by/location ☐ BLOOM

☐ Website ☐ Facebook ☐ Google

☐ Doctor: _____ ☐ Healthgrades

☐ Other: _____ ☐ Radio

Previous Dentist _____ Date of last dental visit _____

Your children's names and ages:

_____

_____

What will keep you as a long term patient in our practice?

_____

_____

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Insurance Information

Name of Insured _____ Date of Birth _____ SS # _____

Insurance Co. Name _____

Phone _____

Name of Employer Group Plan _____ Policy # _____

Claim Filing Address _____

City_____ State_____ Zip _____

- ☐ I authorize use of this form on all my insurance submissions.
- ☐ I authorize release of information to all my insurance carriers.
- ☐ I understand that I am responsible for my bill.
- ☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- ☐ I authorize payment directly to my doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.

Payment Options:
Please check preferred option:

- ☐ Visa/MasterCard
- ☐ Cash
- ☐ Check
- ☐ American Express
- ☐ Discover

Signature on File _____ Date _____

Consent: I grant authority to TODD WHITLOCK, D.D.S. to perform dental procedures and treatments that may be necessary.

Signature_____ **Date**_____

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MEDICAL HISTORY

PATIENT NAME:_____ **DATE**:_____

Have you had any of the following at any time?

YES	NO		
☐	☐	Cardiovascular Disease	
☐	☐	Heart attack	Physician's Name:_____
☐	☐	Angina	
☐	☐	Heart murmur	Physician's Phone:_____
☐	☐	Pacemaker	
☐	☐	Prosthetic heart valve	Physician's Address:_____
☐	☐	Congestive Heart Failure	
☐	☐	Prosthetic joint implants - Do you require an antibiotic before dental procedures? Yes or No	Pharmacy:_____
☐	☐	High blood pressure	
☐	☐	Low blood pressure	
☐	☐	Blood or bleeding problems	
☐	☐	Stroke	
☐	☐	Rheumatic fever	
☐	☐	Skin problems, hives, or rashes	
☐	☐	Thyroid Disease or Thyroid problems	
☐	☐	Kidney Disease	
☐	☐	Diabetes	
☐	☐	Stomach problems or intestinal problems	
☐	☐	Epilepsy	
☐	☐	Fainting spells or seizures	
☐	☐	Nervous condition	
☐	☐	Fever blisters or cold sores	
☐	☐	Sinus trouble	
☐	☐	Arthritis	
☐	☐	Osteoporosis	
☐	☐	Hepatitis, Jaundice, or Liver Disease	
☐	☐	Systemic Lupus	
☐	☐	Rheumatoid arthritis	
☐	☐	Emphysema/COPD	
☐	☐	Asthma	
☐	☐	Herpes	
☐	☐	Venereal disease (gonorrhea, syphilis)	
☐	☐	Glaucoma	
☐	☐	Hearing Aid	
☐	☐	AIDS or HIV infection	
☐	☐	Tuberculosis	
☐	☐	Cancer, Type and Treatment_____	
☐	☐	Alcoholism	
☐	☐	Drug addiction	
☐	☐	Tobacco habit	
☐	☐	Seasonal Allergies (Hay fever)	
☐	☐	Latex sensitivity or allergy	
☐	☐	Are you allergic to any medications? Please List:_____	
☐	☐	Are you currently taking any medications (including aspirin)? Please List:_____	
		_____	
☐	☐	Are you currenlty or have you taken bone density medications? Please List drug name and dates taken:_____	
		_____	
☐	☐	(Child) Are your immunizations current?	
☐	☐	Are you in good health?	
☐	☐	Are you pregnant?	
☐	☐	Do you have any disease, condition, or problem not listed?_____	
		_____	

If you could change anything about your smile, what would it be?

☐younger ☐cover stains
☐lengthen teeth ☐shorten teeth
☐brighter ☐straighten teeth
☐close spaces ☐repair chipped teeth
☐replace missing teeth
☐other: _____

Please check any of the following conditions that apply to you.

☐bad breath
☐bleeding gums
☐clicking or popping jaw
☐food collection between teeth
☐grinding teeth
☐loose teeth or broken fillings
☐periodontal treatment
☐sensitivity to cold
☐sensitivity to heat
☐sensitivity to sweets
☐sensitivity when biting
☐sores or growths in your mouth

The above information is accurate to the best of my knowledge.

Patient Signature_____

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Patient:_____ **Date:**_____

Financial Options

In our office, we do not want money to be a problem for you. We want you to feel comfortable and satisfied with the financial arrangements regarding your dentistry. We encourage you to enter into a financial arrangement that is comfortable for you. For your ease and convenience, we offer several types of financial options.

1. **Payment in Full**
   Payment in full is required when treatment begins. For your convenience, we accept *Visa*, *Mastercard*, *Discover*, and *American Express* as well as, *cash* or *check*.

2. **Two Equal Payments**
   Payment may be divided into two equal payments for procedures that require more than one appointment. One half is to be paid on the day treatment begins; the remaining half is to be paid when treatment is complete.

3. **Care Credit Finance**
   The total fee may be paid in 12 months same as cash. Minimum amount of $300.00 and higher financed. Good credit standing required.

4. **Dental Insurance**
   Co-pay is required the day of service for all restorative, periodontal, and endodontic treatment.

I understand my dental insurance is a contract between the insurance carrier and me and not between Dr. Whitlock and the insurance carrier. Therefore, I am responsible for all dental treatment. Payments received by Dr. Whitlock from my insurance carrier will either be credited to my account or refunded to me if I have paid the dental fees incurred. I understand any fees not covered by insurance are the patient's responsibility.

I understand that if this account is referred to a collection agency, I am responsible for all collection fees, court costs, and attorney fees.

I accept option #_____ to pay for my dental treatment.

_____ _____

Patient's Signature **Date**