MB DENTAL
COSMETIC AND FAMILY DENTISTRY

Dr. Amanda G. Bourff

Patient Information

Name _____ **SS#** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone(**)** _____ **Cell(** **)** _____ **DOB** _____ **Age** _____

Email _____ **Sex** _____

Status: Sing Mar Wid Sep Div _____ **Occupation** _____

Employer _____ **Bus. Phone** _____

Business Address _____

How were you referred? _____

Notify in case of emergency _____ **Phone** _____

Primary Insurance (If you have provided us with a card, you may skip this portion)

Responsible Party for Account _____ **Responsible Party Employer** _____

DOB _____ **SS#** _____ **Insurance Company Name** _____

Is patient covered by additional insurance? Y N _____

Subscriber Name _____ **DOB** _____ **SS#** _____

Subscriber's Employer _____

Dental History

What would you like us to do today? _____ **Are you in dental discomfort?** _____

Previous dentist _____ **Address** _____

Email _____ **Phone** _____

Date of last dental care _____ **Date of last Xrays** _____

Please circle Y or N to the following questions concerning your dental health.

Y N Bad Breath	**Y N Clenching/Grinding**	**Y N Sensitivity/Sweets**
Y N Food Collection	**Y N Clicking/Popping Jaw**	**Y N Sensitivity/Biting**
Y N Broken Fillings	**Y N Sores/Growths**	**Y N Sensitivity/Cold**

Medical History

Physicians Name _____ **Phone#** _____

Date of last visit _____ **Have you had serious illness? Y N**

Describe _____

Are you currently under a physicians care? Y N (explain) _____

Have you ever had a blood transfusion? Y N (explain) _____

Have you ever taken Fen-Phen/Redux Y N (explain) _____

Are you pregnant? Y N Nursing Y N Using Birth Control Y N

Please circle Y or N to the following questions concerning ***YOUR*** medical history.

Y N AIDS/HIV	Y N Cough (Chronic)	Y N Kidney Disease	Y N Shortness of breathe
Y N Anaphylaxis	Y N Coughing Up Blood	Y N Liver Disease	Y N Skin Rash
Y N Anemia	Y N Diabetes	Y N Material Allergies	Y N Spina Bifida
Y N Arthritis/Rheumatism	Y N Epilepsy	Y N Nervous Problems	Y N Stroke
Y N Artificial Heart Valve	Y N Fainting	Y N Pacemaker/Heart	Y N Surgical Implant
Y N Artificial Joints	Y N Food Allergies	Surgery	Y N Swelling Feet/Ankles
Y N Asthma	Y N Glaucoma	Y N Psychiatric Care	Y N Thyroid Problems
Y N Atopic (Allergy Prone)	Y N Headaches	Y N Rapid Weight Gain/	Y N Smoking/Vaping
Y N Back Problems	Y N Heart Murmur	Loss	Y N Tobacco Habit
Y N Blood Disease	Y N Hemophilia/Bleeding	Y N Radiation Treatment	Y N Tonsillitis
Y N Cancer (Describe)	Y N Herpes	Y N Respiratory Disease	Y N Tuberculosis
Y N Chemical Dependency	Y N Hepatitis	Y N Rheumatic/Scarlet	Y N Ulcer/Colitis
Y N Circulatory Problems	Y N High Blood Pressure	Fever	Y N Venereal Disease
Y N Cortisone Treatments	Y N Jaw Pain	Y N Shingles	

NOTES:_____

_____

_____

Is patient currently taking any medications? Please list.

_____

_____

Does patient have any drug allergies? Please list.

_____

_____

Please help us get to know you and serve you better.

Would you be interested in prescription hygiene appointments? (When Eligible) **Y** **N**

Prescription hygiene is an option to see patients, who have had an exam with the doctor within the last 7 months, on days that the doctor may be unavailable.

Are you available for appointments on short notice? **Y** **N**

When?_____

Are there any days that you absolutely cannot come in? **Y** **N**

When?_____

Authorization and Consent to Treat

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to assist in determining appropriate dental treatment. If there is any change in my medical status I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all subsequent insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I, undersigned, consent to the performing of the dental and oral surgery procedures agreed upon to be necessary and advisable. This may include, but not limited to the use of local anesthetic, as indicated.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY OR PATIENT (IF OVER 18 YEARS OLD) **DATE**

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Records and or Xray Release Request

Indiana Code 16-39-1-1 thru 16-39-1-9 requires this form to be completed in order to obtain dental records. I hereby authorize Dr. Amanda Bourff to release all records and any information including diagnosis, treatment and/or examination and relative x-rays for the patients named below.

PATIENT'S NAME PATIENT'S DATE OF BIRTH

_____
_____
_____
_____
_____
_____

FAMILY ADDRESS:

_____

RECORDS RELEASE REQUEST MADE BY:

_____
PLEASE PRINT

PLEASE FORWARD ALL RECORDS TO: (PLEASE PROVIDE DENTIST'S NAME, ADDRESS & EMAIL ADDRESS IF APPLICABLE)

_____
_____
_____

_____ _____
SIGNATURE OF RESPONSIBLE PARTY OR PATIENT (IF OVER 18 YEARS OLD) DATE

_____
PRINTED NAME

PLEASE RETURN THIS FORM TO OUR OFFICE AT YOUR EARLIEST CONVENIENCE AND YOUR REQUEST WILL BE PROCESSED AS SOON AS POSSIBLE. THANK YOU EMAIL: INFO@ZIONSVILLEDDS.COM OR FAX 317-873-6708

This consent to release records is subject to revocation at any time, except to the extent that action has been taken in reliance on the consent. It is void in 90 days if not previously revoked.

Dr. Amanda G. Bourff
55 Brendon Way, Ste. 200
Zionsville, IN 46077
317-873-6750

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CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, _____, Date of Birth_____, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis(es), test results, dates of service.

- Sensitive Protected Health Information (HIV-related information)
- You may disclose information to my family members and/or non-family members.

Please list the name, phone number and relationship

Name	**Phone Number**	**Relationship**

Please check all that apply:

- ☐ You may leave Protected Health Information on my answering machine/voicemail.
- ☐ You may leave me a text message: Phone Number_____
- ☐ You may email me (unencrypted) for dental appointments:
  - Email Address:_____
- ☐ You may fax me for dental information: Fax Number:_____
- ☐ Other:_____

I have received a copy of this office's Notice of Privacy Practices.

Printed Name:_____

Signature:_____
(Patient's Signature (or Guardian, if minor))

Date:_____

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify) _____