Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form ***completely*** in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

Whom may we thank for referring you _____

Today's Date _____

Patient Information

Sex □M □F

Patient's Name _____Home Phone_____ Cell Phone_____

Address _____ City _____State _____ Zip _____

E-mail Address_____SSN:_____DOB: _____

Check Appropriate Box □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Patient's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Name of Person Responsible for this Account _____ Relationship to Patient _____

If Patient is a Student, Name of School/College _____ City _____ State_____

Person to Contact in Case of Emergency _____ Phone _____

Name of Family Physician _____Phone _____

Name of Family Pharmacy _____ Phone # or Location _____

Primary Dental Insurance Information

Name of Insured _____Relationship to Patient _____

Date of Birth _____Social Security # _____Date Employed:_____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Phone # _____

Ins. Co. Address _____City _____ State _____ Zip _____

Employee ID # _____ Group #_____

Do you have Secondary Dental Insurance? Y or N

Primary Medical Insurance Information

Name of Insured _____ Relationship to Patient _____

Date of Birth _____Social Security # _____Date Employed:_____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Name of Insurance Company _____ Phone # _____

Insurance Company Address _____ City _____ State _____ Zip _____

Employee ID # _____ Group #_____

Do you have Secondary Medical Insurance? Y or N

Over Please

Patient Medical History

Height _____ Weight _____

	Yes	No
1. Are you under medical treatment now?……..	□	□
2. Have you ever been hospitalized for any surgical operations or serious illness?……..	□	□
3. Are you taking any medication(s) Including non-prescription medicine? ……	□	□

If yes, what medication(s) are you taking?

Medication	Reason for Taking

	Yes	No
5. Are you allergic to or have you had any reactions to the following?……	□	□
Local Anesthetics (e.g. novocaine)……....	□	□
Penicillin or other Antibiotics……....	□	□
Other……..…….….....	□	□

If yes, please list:_____

6. **Women Only:**

a) Are you pregnant or think you may be pregnant?…	□	□
b) Are you nursing?……..	□	□
c) Are you taking birth control pills? ……..	□	□
d) Have you had any problems with a past pregnancy?	□	□

4. Do you use smoke or use tobacco?…… □ □

7. **Do you** have **or have you** ever had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	□	□	Heart Condition	□	□	Chest Pains	□	□
Heart Surgery	□	□	Cardiac Pacemaker	□	□	Sickle Cell Disease	□	□
Rheumatic Fever	□	□	Heart Murmur	□	□	Stroke	□	□
Swollen Ankles	□	□	Blood Transfusion	□	□	Hay Fever or Asthma	□	□
Epilepsy or Seizures	□	□	Bruise Easily	□	□	Tuberculosis	□	□
Low Blood Pressure	□	□	Emphysema	□	□	Radiation Therapy	□	□
Artificial Heart Valve	□	□	Cancer or Tumor	□	□	Glaucoma	□	□
Anemia	□	□	Arthritis	□	□	Artificial Joint	□	□
Diabetes	□	□	Lung Disease	□	□	Liver Disease	□	□
Kidney Disease	□	□	Hepatitis A (infectious)	□	□	Hepatitis B (serum)	□	□
Aids or HIV Infection	□	□	Exposure to HIV	□	□	Thyroid Disease	□	□
Skin rashes or Hives	□	□	Chemotherapy	□	□	Pain in Joints	□	□
Psychiatric Treatment	□	□	Alcoholism	□	□	Other _____	□	□

Patient Dental History

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	□	□	8. Do you have missing teeth?	□	□
2. Are your teeth sensitive to hot or cold?	□	□	9. Do you clench or grind your teeth?	□	□
3. Are your teeth sensitive to sweet or sour?	□	□	10. Do you bite you lips or cheek often?	□	□
4. Do you have pain or popping in joints?	□	□	11. Have you ever had trauma to face or jaw?	□	□
5. Do you have unsatisfactory dentures?	□	□	12. Have you had any Orthodontic Treatment?	□	□
6. Do you have unsatisfactory crowns?	□	□	13. Have you had any Periodontal Treatment?	□	□
7. Do you have difficulty chewing?	□	□	14. Do you like the appearance of teeth or gums?	□	□

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Phelps to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize my insurance company to pay directly to Dr. Phelps or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In case of payment default, I will become responsible for any costs of collection and attorney fees incurred.

X _____

Signature of patient or parent if minor

8902 N. Meridian St., Suite 139
Indianapolis, IN 46260

PROSTHODONTIST
JOHN R. PHELPS
DDS, MSD

www.johnrphelpsdds.com
(317) 818.9858 office
(317) 818.1716 fax

Welcome and thank you for being a part of our Prosthodontic practice. As strong, trusting relationships allow the best treatment progress and results, we feel it is important to present our philosophy and practice guidelines. We ask that you please read this document carefully.

Your signature is required on this form, prior to treatment, as acknowledgement that you have reviewed and understand our philosophy and guidelines contained below and this office's Notice of Privacy Practices posted in the waiting area. You may request a paper copy of these privacy practices at anytime. Thank you for your kind cooperation.

PHILOSOPHY:

- We feel it is necessary for you to understand that you are the one primarily responsible for your oral health. Our desire and obligation is to perform necessary and appropriate diagnostic procedures to determine your oral health status and personal expectations and desires. We are here to recreate or reconstruct to the best of our ability, your teeth and related structures with procedures, techniques and restorations that are in line with your expectations and desires. We must appreciate and respect the various limitations that your unique conditions present and consider them when developing your plan.

- We are here to inform and advise you of ways to change or improve your teeth and of things you should do to help achieve and better maintain your results.

- We recognize that when dealing with individuals and biologic systems, there are always unknown elements that can alter treatment and no results can be guaranteed.

We value your trust and confidence and thank you for the privilege to improve your smile and oral health.

APPOINTMENT GUIDELINES:

- In order to provide the best type of care in the optimal setting, it is imperative that appointed times be respected. Time in all of our schedules will be designated for your care, and we must be considerate of others. We require forty-eight hours notice by you if any change in your appointed time must be made. Arriving late for an appointment may necessitate re-appointment. Failure to give adequate notice or missing an appointment may result in a charge for a failed appointment fee, and/or dismissal from our practice.

FINANCIAL GUIDELINES:

- We want to create a positive relationship with you to match the excellent dental treatment and personal care you will receive. For this reason, we have developed the following financial considerations, which we believe you will find to be of great assistance.

1. Payment in Full at start of treatment

   - If you have dental insurance, we will be happy to submit a claim for services rendered and ask that your insurance company reimburse you for their contracted portion of your expense.

   - We will be happy to submit a Predetermination to your insurance company; however, it is important that you remember that a Predetermination Explanation of Benefits **is not** a guarantee of payment.

2. Payment Plans (CareCredit)

   - With prior credit approval you may elect to use CareCredit. Alternatively, you may elect to use any financial institution of your choice.

3. Partial Payments

   - Partial payments may be made over the period of time required to complete treatment, as long as **total amount due is paid in full when current treatment is completed**. Payment amounts and due dates can be scheduled prior to beginning treatment.

Our practice is committed to providing the best treatment for our patients and our fees are determined accordingly. You are responsible for payment regardless of any insurance company's arbitrary determination of ***usual and customary rates***.

At your request you may obtain a copy of this form after you sign it. Thank you for your attention to these important matters.

By signing below, I certify that I have read and understand the above information and have reviewed the Notice of Privacy Practices for this practice posted in the waiting area. I agree to be responsible for my appointment times and payment of all services rendered on my behalf or my dependents. I also understand that past due accounts are subject to service charges, and all costs of collection, including attorney and legal fees.

X _____ _____

Signature of patient or parent if a minor — Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have read and/or received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

I give permission for John R. Phelps, DDS, MSD and staff members to discuss my treatment, lab results, appointment dates and times and account information with the following:

Name:	**Relationship to Patient:**
_____	_____
_____	_____
_____	_____

Please check the items below in which you give us permission to leave a message. If an item is not checked, we may attempt to contact you; however, we will not leave a message.

Home_____ **Cell**_____ **Work**_____ **Email**_____

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)

_____

_____

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JOHN R. PHELPS DDS, PC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 1, 2014 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location and we will provide copies of the new Notice upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services your receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care in the payment for you care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using a disclosing or PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage. If you want copies mailed to you. Contact us using the information listed at the end of this notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting written request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purpose of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payment will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email.)

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U. S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

PROSTHODONTIST
JOHN R. PHELPS
DDS, MSD

We support your right to the privacy of health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Ann Marie Phelps

Telephone: (317) 818-9858

Address: 8902 N. Meridian St., Ste. 139, Indianapolis, IN 46260

Email: jrp3office@sbcglobal.net

WELCOME TO OUR PRACTICE

Welcome to the Prosthodontics and Restorative Dentistry practice of John R. Phelps, DDS. We would like to thank you for choosing our practice to meet your restorative needs. We are dedicated to providing you with the high quality care you expect in a pleasant, caring and comfortable setting.

Understanding treatment allows for informed decisions. Dr. Phelps will first spend time talking and getting to know your concerns and desires before making a treatment plan. During this time we urge you to discuss any questions or concerns you may have. Secondly, he will discuss a treatment plan that is best for you and meets your needs, expectations and goals. Once you have agreed to a treatment plan designed for you, the restoration process will begin. Appointments will be scheduled conveniently and promptly to meet your needs.

We strive to offer the highest quality services and are continually seeking new ways to improve our office for our patients. We appreciate any input our patients can provide to help us better serve their needs.

WHAT IS A PROSTHODONTIST?

Prosthodontists are dental specialists in the restoration and replacement of teeth. After completing four years of dental school, Prosthodontists receive three years of specialized training in an American Dental Association (ADA) accredited graduate education program. Prosthodontics is one of eight specialties recognized by the ADA.

Rigorous training and experience provide Prosthodontists with the special understanding of the dynamics of the smile, the preservation of a healthy mouth, and the creation of tooth replacements.

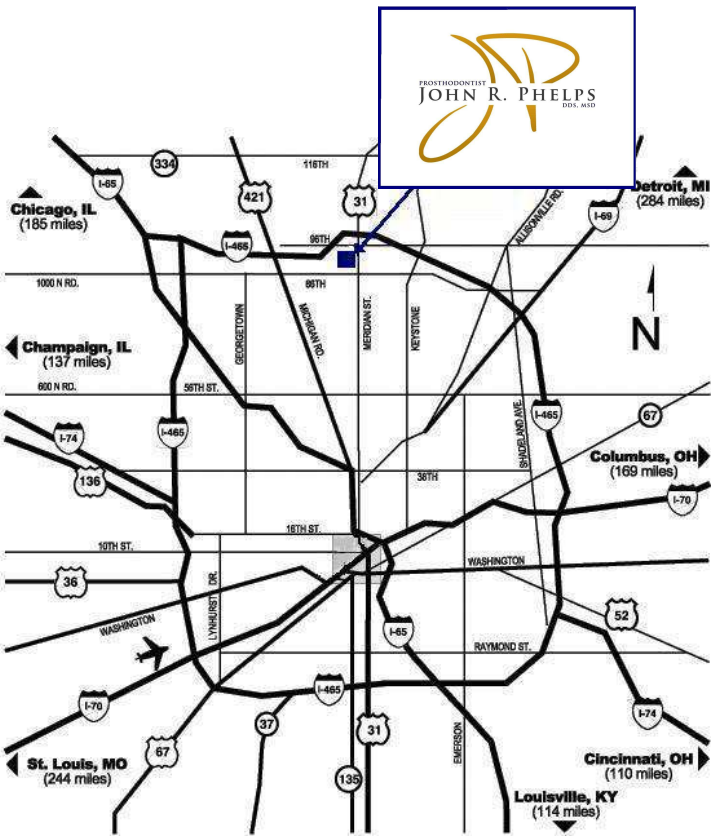
Serving as the “architect” of a dental treatment plan, Prosthodontists collaborate with general dentists, specialists and other health professionals to develop solutions to your dental concerns.

DR. JOHN R. PHELPS

Dr. Phelps has practiced Prosthodontics in Indiana since 1992. He received his DDS degree at Indiana University in 1989, and completed a three-year post-doctoral Prosthodontic program in 1992. He is a member of the American Dental Association, the American College of Prosthodontists, the Indiana Dental Association, the Indianapolis District Dental Society, and the Indianapolis Chamber of Commerce. He is a former President of the Indiana chapter of the American College of Prosthodontists. Dr. Phelps was on the faculty of the Indiana University School of Dentistry for 14 years.

OUR TREATMENT PHILOSPHY

- DIAGNOSE — Gather and evaluate all pertinent information
- PLAN — Review all options and devise a plan address your concerns
- RESTORE — Carry out the planned procedures
- MAINTAIN — Establish continued care to ensure lasting results



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