NETTER
FAMILY DENTAL

Dr. Ronnie L. Netter DMD . Dr. Payton C. Larson DMD

To Our New Patients

On behalf of the staff and myself I would like to welcome you to our growing family of patients. We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally.

Our goal is to provide you and your family with the highest quality of dental care in a gentle, efficient and pleasant manner. We recognize that each patient is an individual and we strive to help you retain your teeth in comfort, function, and aesthetics for a lifetime. Our focus is to clearly inform you of your oral conditions so you can participate in the creation and maintenance of a nice, healthy smile.

During your first visit a thorough examination will be performed and we will discuss your dental needs and desires. This will include x-rays and other information gathering procedures to aid in a customized plan for you. Any dental treatment needed will be provided in as few well planned appointments as necessary to restore optimum oral health.

Enclosed you will find our new patient information forms. Please fill these out and bring them with you to your first appointment along with a list of any medications that you take. We all are looking forward to a relaxed and pleasant visit with you.

Thank you again for selecting us to provide your oral health care. If you have any questions, please feel free to contact the office directly at (812)-941-9533.

Sincerely,

Dr. Ronnie Netter D.M.D

PATIENT REGISTRATION:

Responsible Party (If someone other than the patient): _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Date of Birth: _____ Soc. Sec: _____

PATIENT INFORMATION:

Full Name: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Sex: (Circle) F M Marital Status: Single Married Divorced Widowed Child
Email: _____ Opt in for Emails/Text: Y N
Date of Birth: _____ Soc. Sec: _____

PRIMARY INSURANCE INFORMATION:

Subscriber Name: _____DOB: _____
Relationship to Patient: (Circle) Self Spouse Child Guardian/Caregiver Other
Employer: _____
Employer Address: _____
Insurance Company: _____
Insurance Address: _____ City, State: _____
Group Name: _____ Group Number: _____
Subscriber ID Number: _____

SECONDARY INSURANCE INFORMATION:

Subscriber Name: _____
Relationship to Patient: (Circle) Self Spouse Child Guardian/Caregiver Other
Employer: _____
Employer Address: _____ City, State: _____
Insurance Company: _____
Insurance Address: _____ City, State: _____
Group Name: _____ Group Number: _____
Subscriber ID Number: _____

- What do you want to accomplish today? _____
- What could we do today to make this a positive experience for you?
  _____
- If you could change one thing about your smile, what would it be?
  _____
- Would you like your teeth whiter? _____
- Do you grind or clench your teeth? _____ If so, any jaw pain or headaches? _____
- Do your gums bleed when you brush and floss? _____
- Have you ever been treated for gum disease? _____
- Have you been unhappy with any previous dental care? _____
  If so, what happened? _____
- How long has it been since you've seen a dentist? _____
  If not for a cleaning, how long since your last cleaning? _____
- Are you missing any teeth? Y N If so, how long have they been missing? _____
- Do you have any crowns or bridges? Y N If so, How old? _____
- Have you ever had an adverse reaction to a local anesthetic? _____
- Do you have sleep apnea? Do you wear a C-PAP Machine? _____
- How did you hear about our office? _____

- How would you describe your attitude about your teeth: (Check one)
  ___ I only want to treat something when it's broken or hurting
  ___ I only want to treat the most immediate needs to stop dental disease
  ___ I want to be as healthy as possible
  ___ I want to be healthy and prevent future problems
  ___ I want to be healthy, prevent future problems and have the most attractive smile I can.

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MEDICAL HISTORY:

- Are you under a physician's care now other than routine care? Y N
- Have you ever been hospitalized for a major operation? Y N
  - If yes, please explain: _____
- Have you ever had a serious head or neck injury? Y N
  - If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Y N
  - If yes, please list: _____
- Do you take, or have you taken, Phen-Fen or Redux? Y N
- Are you on a special diet? Y N
  - If yes, please explain: _____
- Do you use controlled substances? Y N
- Have you ever had a joint replaced? Y N
  - If yes, please list which joint and the dates placed: _____
- Do you take any blood thinners other than daily asprin? Y N
  - If yes, please explain: _____
- Do you, or have you ever taken any drugs knows as bisphosphonates? Y N
  (ie Fosomax, Bonivia, Zometa, Actonel) 0 If yes, please list: _____
- Do you use tobacco? (Cigarettes/Cigar, Smokeless, or ECigg) Y N
- *FOR WOMEN*: Are you pregnant/ trying to get pregnant? Y N
  - Are you currently nursing? Y N
  - Taking oral contraceptives ? Y N

- Are you allergic to any of the following? (Circle if yes)
  Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
  Other If yes, please explain: _____

- Do you have, or have you ever had, any of the following? (Check if yes)

__ AIDS/HIV Positive	__ Alzheimer's Disease	__ Anaphylaxis	__ Anemia
__ Angina	__ Arthritis/Gout	__ Artificial Heart Valve	__ Artificial Joint
__ Asthma	__ Blood Disease	__ Blood Transfusion	__ Breathing Problems
__ Bruise Easily	__ Cancer	__ Chemotherapy	__ Chest Pains
__ Cold Sores/Fever Blisters	__ Convulsions	__ Diabetes	__ Congenital Heart Disorder
__ Cortisone Medicine	__ Drug Addiction	__ Easily Winded	__ Emphysema
__ Epilepsy/Seizures	__ Excessive Bleeding	__ Excessive Thirst	__ Fainting Spells/Dizziness
__ Frequent Cough	__ Frequent Diarrhea	__ Frequent Headaches	__ Genital Herpes
__ Glaucoma	__ Hay Fever	__ Heart Attack/Failure	__ Heart Murmur
__ Pace Maker/Defibrillator	__ Heart Trouble/Disease	__ Hemophilia	__ Hepatitis A, B or C
__ Herpes	__ High blood pressure	__ Hives/Rash	__ Hypoglycemia
__ Irregular Heartbeat	__ Kidney problems	__ Leukemia	__ Liver Disease
__ Low Blood Pressure	__ Lung Disease	__ Mitral Valve Prolapse	__ Jaw Pain
__ Parathyroid Disease	__ Psychiatric Care	__ Radiation Treatment	__ Recent weight loss
__ Renal Dialysis	__ Rheumatism	__ Scarlet Fever	__ Shingles
__ Sickle Cell Disease	__ Sinus Trouble	__ Spina Bifida	__ Stroke
__ Stomach Disease	__ Thyroid Disease	__ Tuberculosis	__ Tumors/ Growth
__ Ulcers	__ Venereal Disease	__ Yellow Jaundice	

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) heath. It is my responsibility to inform the dental office of any changes in medical status:

Signature of Patient, Parent, or Guardia n_____ Date _____

- **Appointments:**

Since appointment times are reserved exclusively for each patient, we ask that you please notify the office 24 hours in advance to your scheduled appointment time if you are unable to keep your appointment. Another patient who needs our care could be scheduled if we had ample time. We do understand that emergencies occur, but we ask for your assistance in this regard. If you do not call to cancel or fail to show for your appointment, you may be subjected to a $30.00 missed appointment charge. If you miss three (3) consecutive appointments, we may request that you seek dental care from another office that can accommodate your schedule.

INITIAL: _____

- **Insurance Claims:**

We file dental insurance claims as a courtesy to our patients. We do not have a contract with your dental insurance, only you do. Therefore, we are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We will assist you in estimating your portion of the cost of treatment, but we cannot guarantee what your insurance may or may not do with your claim. Even with a pre-estimate submitted to your insurance company prior to any treatment, your insurance company, nor our office, can guarantee payment until the claim has been processed and payment has been issued.

Dental insurance is intended to aid in receiving dental care. On average, most dental plans pay between 50%-80% of the average total fee. Some plans pay more, some plans pay less. The percentage paid may be determined by how much you and your employer have paid for coverage or the type of contract your employer has set up with the insurance company.

* * Insurance providers that we work with may change at any time and without notice. If you have any questions, please contact your insurance company directly.

INITIAL: _____

- **Co-payments:**

Payment is expected at the time of service unless arrangements have been made with our office in advance. In the event reimbursement is expected from a third-party, it is the responsibility of the patient/parent to pay for the services rendered and seek reimbursement from the third-parties. Our office is not responsible for seeking payment from third-parties.

INITIAL: _____

- **Accounts:**

Any balance that remains outstanding is subject to a finance charge of 1% or a minimum of $1.00. Any account that remains outstanding for more than 90+ days will be turned over to a third-party collection agency: Additional fees will be added to the account for this action. Once referred for collections, we can no longer provide services until your balance is paid in full.

INITIAL: _____

- **Restorations:**

Most insurance companies downgrade the payment for a composite (white) filling placed in posterior (molar) teeth. Most insurance companies have an allowance for amalgam (silver) fillings. If you choose to have the composite material placed in these fillings, you will be subjected to not only your deductible and co-payment (usually 50-80%) but also the difference between the fee for the amalgam material to the fee for the composite which can be anywhere from $15 - $100, depending on your plan.

INITIAL: _____

- **Forms of Payment Accepted:**

Our office accepts Visa, MasterCard, Discover, American Express, as well as debit cards which bear the Visa or MasterCard logo. As always, we will happily accept cash or checks.

INITIAL: _____

- **Payment Plans:**

We expect all patient portions and deductibles to be paid when the service is rendered. We implement and enforce this policy to keep costs down for our patients. Prior to treatment, one of our staff will provide an estimate of the treatment costs or copayment. Usually the copay is a close estimate but, in some cases, an additional amount may be due.

INITIAL: _____

- **Financing Options**:

As a courtesy to our patients, we are pleased to offer the Care Credit card, the nation's leading payment program. With care Credit we can finance 100% of your dental care, and there are no upfront costs, no annual fees, and no pre-payment penalties. You can start your treatment today and conveniently pay with low, monthly payments. Care credit can be used by the whole family for ongoing treatment without reapplying. It only takes a few minutes to apply for Care Credit and you will receive an instant decision. Apply at www.carecredit.com or see one of our staff for more details.

INITIAL: _____

I acknowledge that I have reviewed and agreed to all of the above policies:

Print Name: _____ Signature: _____

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this offices, Notice of Privacy Practices.

_____
Please Print Name

_____ _____
Signature Date

OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due it:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify): _____

CONSENT FOR US AND DISCLOSURE OF HEALTH INFORMATION

Section: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: ( ) - _____ - _____
Email: _____

Section B: 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 options.

Notice of Privacy Practices: You have the right to read our Notice of Privacy practices before you decided 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. We encourage you to read our notice 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:

Netter Family Dental LLC
Dr. Ronnie Netter DMD
3819 Charlestown Road
New Albany, IN 47150

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 can decline to treat you or to continue treating you if you revoke this Consent.

Signature: I, _____, have had full opportunity to read and consider the consent of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____