What to Expect with your First Cleaning Visit

- Review of Registration and Consent forms
- Review of Medical History and modification of treatment
- Courtesy Dental Benefits Review (if applicable)
- Blood Pressure screening
- Cavity detection x-rays
- Intra-oral photos taken
- Oral Cancer screening
- Charting and review of existing teeth and fillings
- Periodontal (Gum) measurements for Periodontal (Gum) Disease screening
- Removal of soft (plaque) and hardened (calculus or tartar) build up
- Removal of coffee, tea, and tobacco stains
- Polish and flossing
- Fluoride treatment
- Review of personalized oral hygiene instructions
- Comprehensive dental examination by Dr. Knuth
- Clean and recheck fit of dental appliances (if applicable)
- Evaluate cosmetic options to give you a more confident smile
- Discussion of treatment solution

Greencastle HOMETOWN DENTAL
Dennis M. Knuth, DDS

(765) 653-4081 | 1113 INDIANAPOLIS RD | GREENCASTLE, IN | WWW.GREENCASTLEHOMETOWNDENTAL.COM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: M F

Preferred Name: _____ SSN: _____ Status: MARRIED WIDOWED DIVORCED SINGLE

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Occupation: _____ Employer: _____

Whom may we thank for referring you to our office?
How did you hear about our office?

_____

Preferred contact method for courtesy appointment reminders

	YES	NO
Home Phone _____	☐	☐
Cell Phone _____	☐	☐
Text Message_____	☐	☐
E-mail _____	☐	☐

BILLING AND INSURANCE INFORMATION: ☐ Not Covered by dental insurance

Subscriber: _____ Date of Birth: _____ SSN: _____

Dental Insurance: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Please list any individuals you authorize our office to discuss your health information with:

_____

DENTAL INFORMATION

What is the reason for your dental visit?

_____

Date of last visit to dentist _____

Have you had any problems associated with previous dental treatment? ☐ YES ☐ NO

Please Explain: _____

Are you apprehensive or anxious about dental treatment? Please circle level on 1 to 10 scale. Low 1 2 3 4 5 6 7 8 9 10 High

Are you dissatisfied with the appearance of your teeth? ☐ YES ☐ NO

Please Explain: _____

	YES	NO
Does food or floss catch between your teeth? _____	☐	☐
Do you have difficulty in chewing your food?_____	☐	☐
Do you ever experience a dry mouth?_____	☐	☐
Do you currently have dental pain or discomfort?_____	☐	☐
Are your teeth sensitive to		
Hot or cold liquids_____	☐	☐
Sweets_____	☐	☐
Chewing_____	☐	☐

	YES	NO
Do your gums bleed easily?_____	☐	☐
Do your gums feel swollen or tender?_____	☐	☐
Have you ever had any periodontal (gum) treatments?___	☐	☐
Do you have any pain or discomfort in your jaw?_____	☐	☐
Do you clench or grind your teeth frequently?_____	☐	☐
Does it hurt when you chew or open wide to take a bite?__	☐	☐

MEDICAL INFORMATION

Do you have, or have you had, any of the following?

YES NO

Heart

- Artificial (prosthetic) heart valve _____ ☐ ☐
- Previous infective endocarditis _____ ☐ ☐
- Congenital heart disease _____ ☐ ☐
- Damaged valves in transplant heart _____ ☐ ☐
- Heart attack _____ ☐ ☐
- Congestive heart failure _____ ☐ ☐
- Chest Pain _____ ☐ ☐
- Shortness of breath _____ ☐ ☐
- Blood pressure problem _____ ☐ ☐
- Pacemaker _____ ☐ ☐
- Rheumatic fever _____ ☐ ☐
- Recent Heart stent placed _____ ☐ ☐

GI

- Ulcers _____ ☐ ☐
- Weight gain or loss _____ ☐ ☐
- Gastric reflux/persistent heartburn _____ ☐ ☐
- Diabetes _____ ☐ ☐

Blood Problems

- Abnormal bleeding _____ ☐ ☐
- Anemia _____ ☐ ☐
- Radiation or chemotherapy _____ ☐ ☐
- Anticoagulants or blood thinners _____ ☐ ☐

Respiratory

- Tuberculosis _____ ☐ ☐
- COPD _____ ☐ ☐
- Asthma _____ ☐ ☐
- Sinus troubles _____ ☐ ☐

- Kidney problems _____ ☐ ☐
- Do you use tobacco? _____ ☐ ☐
  - What kind? _____

YES NO

Bone & Joint

- Joint Replacement: _____ ☐ ☐
  - What & Date: _____
- Taken Fosamax, Actonel, Boniva, Didronel, Skelid ___ ☐ ☐
- Taken IV bisphosphonates (Aredia or Zometa) _____ ☐ ☐

- Thyroid Problems _____ ☐ ☐
- Stroke _____ ☐ ☐
- Hepatitis, jaundice or liver disease _____ ☐ ☐
- Glaucoma _____ ☐ ☐
- Epilepsy / Seizures _____ ☐ ☐
- Cancer / Tumor _____ ☐ ☐
- HIV positive _____ ☐ ☐
- Herpes or other STD _____ ☐ ☐
- Do you wear contact lenses? _____ ☐ ☐

Allergies - Are you allergic to any of the following

- Local anesthetic (ex. Novocaine) _____ ☐ ☐
- Aspirin, Ibuprofen, Acetaminophen _____ ☐ ☐
- Penicillin or other antibiotic _____ ☐ ☐
- Sulfa Drugs _____ ☐ ☐
- Codeine or other narcotic _____ ☐ ☐
- Metals _____ ☐ ☐
- Latex _____ ☐ ☐
- Barbiturates, sedative, sleeping pills _____ ☐ ☐
- Other _____ ☐ ☐

Women Only - Are you

- Taking birth control pills or hormone replacement? ___ ☐ ☐
- Pregnant _____ ☐ ☐
  - If so, expected delivery date: _____
- Nursing? _____ ☐ ☐

YES NO

Are you under the care of a physician? _____ ☐ ☐
Name: _____
Phone Number: _____

Are you in good health? _____ ☐ ☐

Have there been any changes in your general health in the last year? _____ ☐ ☐

If yes, what condition? _____

Please list name and dosage of current medications (prescription, over the counter,herbals)

_____

_____

_____

_____

I certify that I have read and understand that the information given on this form is accurate. I understand the importance of a truthful health history and that Dr. Knuth and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Knuth, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

CONSENT FOR DENTAL TREATMENT

I hereby authorize Dr. Knuth or his designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Knuth to make a thorough diagnosis of my dental needs. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Signature of Patient/Legal Guardian: _____ Date: _____

GREENCASTLE HOMETOWN DENTAL
DENNIS M KNUTH DDS
1113 INDIANAPOLIS ROAD
GREENCASTLE, IN 46135
765-653-4081

I UNDERSTAND:

I AM RESPONSIBLE FOR MY TOTAL BILL.

I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.

I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME TO OBTAIN PAYMENT FROM MY INSURANCE CARRIER.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL WHEN NECESSARY.

I AUTHORIZE RELEASE TO MY INSURANCE COMPANIES, OR REPRESENTATIVES, ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORD OF TESTAMENT OR EXAMINATION FOR DENTAL TREATMENT.

I ALSO AUTHORIZE AND REQUEST MY COMPANY TO PAY DIRECTLY TO THE ABOVE NAMED DENTIST THE AMOUNT DUE ME IN MY PENDING CLAIM FOR DENTAL TREATMENT OR SERVICES BY REASON OF SUCH TREATMENT OR SERVICES RENDERED.

INSURANCE BENEFITS ARE PAID AT A CERTAIN PERCENTAGE OF USUAL AND CUSTOMARY PER THE INSURANACE COMPANY'S SCHEDULE. THAT AMOUNT MAY BE LESS THAN ACTUAL FEES FOR SERVICES. ALL DIFFERENCES BETWEEN THE INSURANCE PAYMENT AND ACTUAL FEES WILL BE MY RESPONSIBILITY.

IN THE EVENT THE INSURANCE COMPANY SENDS PAYMENT FOR SERVICES DIRECTLY TO ME INSTEAD OF TO THE DOCTOR, I WILL BRING OR SEND THE ENDORSED CHECK TO THE DOCTOR'S OFFICE WITHIN FIFTEEN (15) DAYS OF RECEIVING THE CHECK. THE REMAINDER OF THE ACCOUNT WILL BE MY RESPONSIBILITY.

IN THE EVENT THE INSURANCE COMPANY FAILS TO PAY OR TO RESPOND TO REQUEST FOR PAYMENT OF THE CLAIM IN A REASONABLE TIME PERIOD THE ACCOUNT WILL BE TOTALLY MY RESPONSIBILITY WITHIN NINETY (90) DAYS FO THE DATE OF SERVICE.

ACCOUNTS SHOULD BE PAID IN FULL WITHIN FORTY-FIVE (45) DAYS OF THE INSURANCE PAYMENT OR ALL ACCOUNTS MUST BE PAID IN FULL WITHIN ONE HUNDRED TWENTY (120) DAYS OF THE DATE OF TREATMENT.

AFTER ONE HUNDRED TWENTY (120) DAYS FROM THE TREATMENT DATE, I WILL BE RESPONSIBLE FOR ALL COSTS OF COLLECTION INCLUDING COLLECTION AGENCY FEES (35% REGULAR / 50% LEGAL COLLECTIONS), ATTORNEY FEES, AND COURT COSTS. THESE FEES WILL BE ADDED TO THE TOTAL AMOUNT DUE OF MY ACCOUNT BALANCE.

NAME_____SS#_____

DATE OF BIRTH_____ SIGNATURE_____DATE_____

GREENCASTLE HOMETOWN DENTAL

DENNIS M. KNUTH DDS

PATIENT CONSENT/ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Dr Dennis Knuth, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Privacy Practices ("Policies"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (765) 653-4081 and requesting a revised Notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, You may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPTOF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Name_____ Date_____

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE CONSENT/ACKNOWLEDGEMENT OF NOTICE OF PRIVACY.