Matthew Walton, DDS
488 State Road 135
Greenwood, IN 46143

New Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.
Whom do we thank for referring you?_____

About You

Name:_____ I prefer to be called_____( ) Male ( ) Female

( ) Single ( ) Married ( ) Child Age:_____ SSN:_____ DOB _____

Home Address:_____City_____State_____Zip_____

Home Phone: (___)_____Work:: (_____)_____ext. Cell: (___)_____

E-mail Address:_____

Employer:_____ How long there?_____ Occupation:_____

Employer's Address:_____City_____State_____Zip_____

Person Responsible for Account

Name:_____ Birth Date:___/___/___ Relationship:_____

Billing Address:_____ City_____ State_____ Zip_____

Home Phone: (__)_____Cell: (__)_____

SSN:_____ Employer:_____ Occupation:_____

Spouse Information

Name: _____ Birth date:___/___/____

Employer:_____ Work Phone: (___)_____ext.____ Cell: (___) _____

E-mail address:_____ SSN: _____

Dental Insurance Information

Primary	Secondary
Insurance Co. Name:	Insurance Co. Name:
Phone:( )	Phone:( )
Group/Policy#:	Group/Policy#:
Policy Holder Name:	Policy Holder Name:
Policy Holder SSN:	Policy Holder SSN:
Policy Holder DOB: / /	Policy Holder DOB: / /
Employer:	Employer:

Walton

Name_____ Date_____

Cell Phone #_____ Email_____

Medical History Information

Medical Doctor's name_____

Do you have or have you ever had any of the following? Please check all that apply:

[ ] Allergies/Hay Fever
[ ] Anemia
[ ] Angina/chest pain
[ ] Arthritis
[ ] Artificial Joints*
[ ] Artificial Heart Valves*
[ ] Asthma
[ ] Breathing Problems
[ ] Cancer
[ ] Chemical Dependency
[ ] Chemotherapy
[ ] Convulsions
[ ] Blood Transfusion
[ ] Excessive Bleeding
[ ] Emphysema
[ ] Psychiatric Care
[ ] Diabetes
[ ] Epilepsy/Seizures
[ ] Excessive Thirst
[ ] Fainting or Dizziness
[ ] Fever Blisters/Cold Sore
[ ] Frequent Cough
[ ] Glaucoma
[ ] Heart Disorder(Congenital)*
[ ] Heart Attack/failure*
[ ] Heart Murmur*
[ ] Heart Pace Maker*
[ ] Hemophilia(bleeding)
[ ] Blood Disease
[ ] Bruise Easily
[ ] Lung Disease
[ ] Stomach/Intest. Dis
[ ] Heart Surgery*
[ ] Hepatitis
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Kidney Problems
[ ] Liver Problems
[ ] Mental Disorder
[ ] Mitral Valve Prolapse*
[ ] Osteoporosis
[ ] Radiation Treatment
[ ] Respiratory Problems
[ ] Drug Addiction
[ ] Low Blood Pressure
[ ] Hypoglycemia
[ ] Frequent Diarrhea
[ ] Parathyroid Disease
[ ] Rheumatic Fever
[ ] Rheumatism
[ ] Sickle Cell Disease
[ ] Sinus Problems
[ ] Stroke
[ ] Surgical Shunt*
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers
[ ] Venereal Disease
[ ] Yellow Jaundice
[ ] Irregular heart beat
[ ] Steroid Therapy
[ ] Leukemia
[ ] Cortisone Medicine
[ ] Bisphpsphonates(Fosamax)

***This condition may require a premedication for certain dental procedures, please call prior to appt.**

YES NO
[ ] [ ] Do you have any health problems that were not listed above or need further clarification?

If yes, please explain:_____

[ ] [ ] Are you under the care of a physician currently?

If yes, please explain:_____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, please explain:_____

[ ] [ ] Are you taking any medications or herbals?

Please List:_____

_____

Are you **allergic** to any medications or substances? Please check below
[ ]Latex Rubber [ ]Aspirin [ ]Penicillin [ ]Codeine [ ]Acrylic [ ]Sulfa [ ]Other_____

Smoker: _____Yes _____No How much?_____

WOMEN: [ ]Pregnant/trying to get pregnant [ ]Nursing [ ]Taking oral contraceptives

Signature_____

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DENTAL HEALTH

Please rate your dental health from 1 (poor) – 10 (best) _____ When was your last dental visit?_____

Do you have a specific dental problem? _____ Please describe: _____

Do any of the following cause tooth discomfort: Hot _____ Cold _____ Sweets _____ Chewing _____

How often do you brush? _____ How often do you floss? _____ Do you clench or grind your teeth? _____

Do your gums ever feel tender, swollen or bleed while cleaning? _____

Have you had periodontal treatment in the past? _____ When & Where? _____

Does food catch between your teeth? _____ Do your jaws ever feel tired or ache? _____

Do you have difficulty opening your mouth? _____ Do you hear noises from the jaw joints?_____

Does your jaw get: Locked _____ Stuck _____Go Out _____

Do you have pain in or around the ears or cheeks? _____

Do you have pain while: Chewing _____ Yawning _____ Opening Wide _____

Does your bite feel uncomfortable or unusual? _____ Explain _____

Have you ever had an injury to your jaw, head, or neck? ___ When? _____

Have you previously been treated for a TMJ disorder? _____

If so, when, what, how, and by whom?_____

Do you have specific concerns about your comfort during dental treatment? _____

Are you satisfied with the appearance of your teeth? _____

What would you like to change about your smile? _____

The undersigned hereby authorizes the Doctor or his designated staff
to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor or designated staff to perform any and all forms of treatment, anesthetics, medication, and therapy that may be indicated. I also understand the uses of anesthetic agents embodies a certain risk.

I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor. I agree that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from the insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I also understand that where appropriate, credit reports may be obtained. The undersigned assumes and agrees to pay for all reasonable collection agency fees, reasonable attorney fees, filing fees (court costs), and other fees incurred while collecting the amount due.

X_____

Patient signature (Parent or Guardian) Date

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Appointment Policy

Your appointment time is very important, and is reserved for you. If you are unable to keep your appointment, please let us know no later than 24 hours in advance so that we may schedule a new time. Failure to notify us or give a reasonable amount of notice will result in a missed appointment charge of **$40.00 per hour that you were scheduled.** Failed appointments and same day cancellations may also result in us not reserving time for you in the future. Effective September 1, 2018 a deposit will be required to schedule and hold an appointment for a larger treatment case, needing additional time on the schedule.

We will attempt to contact patients by phone or text one or two days before their scheduled appointment. It is imperative that we have a current phone or text number for our records. If you do not have a phone or text number; or we do not reach you, we ask that you kindly contact us to confirm your scheduled appointment. If you fail to confirm with us, or we are unable to confirm with you, your appointment will be cancelled!

Consent for Dental Services

The undersigned hereby authorizes the Doctor or his designated staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor or designated staff to perform any and all forms of treatment, anesthetics, medication, and therapy that may be indicated. I also understand the uses of anesthetic agents embodies a certain risk.

Dental Insurance

I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor. I agree that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from the insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I also understand that where appropriate, credit reports may be obtained. The undersigned assumes and agrees to pay for all reasonable collection agency fees, reasonable attorney fees, filing fees (court costs), and other fees incurred while collecting the amount due.

We will make every effort possible to assist you with your particular insurance coverage. Although it is not required, we will prepare and submit your insurance claim forms at no cost as a courtesy to you. At your request we will also provide estimates that show the expected insurance reimbursement and patient share for every procedure.

Patient Signature:_____

Date:_____

NOTICE OF PRIVACY PRACTICES

Acknowledgement Form

I acknowledge that I have received the Notice of HIPAA Privacy Practices.

_____ _____

Name of Patient Date of Birth

_____ _____

Patient's Signature Date

_____

Reason given by Patient if Refusing to Sign this Notice

_____

Recorder's Signature

Instructions for Communication

I authorize my doctor or staff to **leave messages** including certain medical information:

YES On my answering machine or voicemail: (Please check any of the following)

- ☐ At Home_____
- ☐ At Work_____
- ☐ On Cell/Mobile_____
- ☐ Email_____

OR with the following individuals: (Please check any of the following)

- ☐ My Spouse or Significant other _____
- ☐ My Son or Daughter _____
- ☐ Any Relative _____
- ☐ Other _____

This may include information such as: (Please check any of the following)

- ☐ Lab Test and X-Ray results
- ☐ Information regarding prescription refills
- ☐ Information regarding appointments
- ☐ Instructions regarding treatment or medications

NO I prefer that my doctor/staff speak to me personally regarding any medical information. Please **do not leave messages** concerning any medical information.

I understand that I may notify the doctor's office at any time of changes to this request, which would require a new form to be completed. I also understand that if I request a copy of my records a duplication fee of $30 may apply.

_____ _____

Signature Date

WALTON FAMILY & COSMETIC DENTISTRY
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DEISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLESE REVIEW IT CAREFULLY.
THE PRVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/24/2008, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new term of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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 at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician and other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: we may use or disclose health information to notify, or assist in the notification of (including, identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Service: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.