THE RECTOR DENTAL GROUP
3905 N Wheeling Ave.
Muncie, IN 47304

The information given will be used in strict confidence to prepare your dental chart.

Date:___________________

Birth date:_________________

Name:____Age:________

Family Physician:____Date of last visit:____________

Whom may we thank for referring you to us:____

Purpose of today's visit (any specific concerns):____

____

Do you have or have you had a history of any of the following?

Heart problems, murmur or surgery	Yes	No	Kidney problems	Yes	No
Rheumatic fever	Yes	No	Hepatitis or jaundice	Yes	No
High or low blood pressure	Yes	No	Fainting spells	Yes	No
Congenital heart lesions	Yes	No	Stroke	Yes	No
Blood disorders (anemia, etc)	Yes	No	Stomach problems or ulcers	Yes	No
Bleeding problem or hemophilia	Yes	No	Thyroid condition	Yes	No
Seizures or epilepsy	Yes	No	Nervousness	Yes	No
Asthma, tuberculosis or lung problems	Yes	No	Tumors, growths or cancer	Yes	No
Arthritis	Yes	No	Psychiatric treatment	Yes	No
Venereal Disease	Yes	No	Other (please explain)	Yes	No

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____

Circle One

Are you in good health...Yes No

Has there been any change in your general health within the past year....................................Yes No

Are you under the care of a physician...Yes No

If so, what is the condition being treated____

Have you had any serious illness or operation...Yes No

If so, what was the illness or operation____

____

Have you had abnormal bleeding associated with a previous extraction or surgery...................Yes No

Are you taking any drugs or medications..Yes No

If so, what____

Are you allergic or have you reacted adversely to any drug or medication...............................Yes No

If so, what____

Have you had serious trouble associated with any previous dental treatment............................Yes No

Do you have any disease, condition or problem not listed above that I should know about......Yes No

If so, explain____

____

Women

Are you pregnant...Yes No

Previous Dentist:____Last Visit:_____________

Spouse's Name:____

Single_______Married_______Divorced_______Widowed______

Your home address: Street______________________________City___________________
State_______________Zip_____________

Home Phone:__________________Cell Phone:________________Email address:________________

Occupation:____

Name and address of business:____Phone #___________

Spouse's Occupation:____

Name and address of business:____Phone #___________

Person responsible for account:____

CONSENT

I certify the truth of all information given. I authorize the release of pertinent information to those persons requiring it for treatment, for the purpose of payment of the account, or credit references. I hereby grant permission to Dr. Rector and/or legally qualified associates to perform those diagnostic and treatment procedures, including local anesthesia, operative procedures, dental radiographs as may be deemed necessary or advisable for the proper diagnosis and treatment.

Patient's Signature:____Date:_______________

Witness:____Date:________________

THIRD PARTY PAYMENT INFORMATION

If your account is to be handled by any other method than direct payment to the office, please complete the following section for our records. Your help with this information aids in expediting your dental claim. Check one of the following:

Insurance:_______________Medicaid:________________

If Insurance:
Insurer's Name:_______________________________________
Address:____
Social Security or Identification #_____________________
Insurance Company:__________________________________
Place of employment:_________________________________

SIGNATURE ON FILE

Patient's Name: ____

Last First Middle Initial

I hereby authorize payment of the dental benefits otherwise payable directly to The Rector Dental Group.

____

Signature (Insured Person) Date

The Rector Dental Group is authorized to provide pertinent information to those persons requiring it for the use of evaluating and administrating claims for benefits.

I authorize the use of this form on all of my insurance submissions.

I permit a copy of this authorization to be used in place of the original.

I understand that I am responsible for my bill.

____

Parent, Legal Guardian or Authorized Person's Signature Date

THE RECTOR DENTAL GROUP

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT, PARENT OR LEGAL GUARDIAN GIVING CONSENT

Patients name:____

Address:____

Telephone:____

Section B: TO THE PATIENT, PARENT OR LEGAL GUARDIAN-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of you, or your child's protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide 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, or your child's protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it 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 change. 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:

Contact Person: Dr. Rector
Telephone: 765-286-4017 Fax: 765-286-0372
Address: 3905 N Wheeling Ave., Muncie, IN 47304-1769

Rights 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 effect any action we took in reliance on this Consent before we received your revocation, and that we 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 contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form I am giving my consent to your use and disclosure of my child's protected health information to carry our treatment, payment activities, and health care operations.

Signature:____Date:________________________________

If this Consent is signed by a personal representative on behalf of the patient, other than the parent, complete the following:

Personal Representative's name:____

Relationship to Patient:____

THE RECTOR DENTAL GROUP
AUTHORIZATION TO RELEASE DENTAL NEEDS

Our mission is to be dedicated to protecting the dental health of our patients. We treat healthy children as well as those with special needs and adults. We are proud to provide dental care to children and adults of the community. Our office combines the latest dental knowledge and technology together with care and compassion. We want every patient to have a positive dental experience. Our expert staff is great in creating this experience. Your commitment along with our excellent care, will allow for a lifetime of healthy teeth and gums.

____

Patients Name   Date of Birth

It is the policy of my office to not release dental patient information about you, unless it is for patient care and treatment or payment. Our office is an open concept. We try to the best of our ability to keep the discussion of patient information to a minimum. If you wish for our dentist and/or office staff to leave messages for you on your home telephone, message number, answering machine, work telephone, voice mail, cell phone, or pager, or to any other person, then you must complete the following:

I authorize The Rector Dental Group or staff to release dental patient information about me by the following methods and agree it is my responsibility for notifying my dentist or office staff whenever I want this to change:

We can call your home or cell number if applicable and leave a message if no answer Yes___No___
We can call you at work Yes___No___
We can communicate with other professional offices and/or insurance companies Concerning patient information Yes___No___
Are you ok with our open concept practice? Yes___No___

You may disclose information to my family members and or non-family members. Please list name and relationship.

<u>NAME</u>   <u>RELATIONSHIP</u>

____

____

____

Patient Signature   Date

____

Witness   Date