Madison Ave Dental
701 N Madison Ave | Greenwood, IN
(317) 881-4305
Info@MadisonAveDentalCare.com

New Patient Information

Name:_____ Date of Birth:_____ Sex:_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone: _____ Cell Phone:_____

Email:_____ Social Security:_____

Check: Minor___ Single___ Married___ Divorced___ Widowed___

Patient (or Guardian) Employer:_____ Phone:_____

Spouse (or Guardian) Employer:_____ Phone:_____

How did you hear about us?_____

Emergency Contact:_____ Phone:_____

Responsible person for account:_____

If you are filling this form out on behalf of another person, what is your relationship?

Name:_____ Relationship:_____

Primary Insurance

Insured's Name:_____

Employer:_____

Member ID/SS#:_____

Insured's DOB:_____

Insurance Co:_____

Insurance Co. Address_____

Insurance Phone#:_____

Group#:_____

Secondary Insurance

Insured's Name:_____

Employer:_____

Member ID/SS#:_____

Insured's DOB:_____

Insurance Co:_____

Insurance Co. Address:_____

Insurance Phone#:_____

Group#:_____

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MADISON AVE DENTAL
Family & Comsetic Dentistry

Medical History Form

Patient	DOB

Are you under a physician's care now?	□ Yes	□ No	If yes..
Have you ever been hospitalized or had a major operation?	□ Yes	□ No	If yes..
Are you taking any medications or drugs?	□ Yes	□ No	If yes..
Have you ever taken Fosamax, Boniva, or any other bisphosphonate?	□ Yes	□ No	If yes..
Have you ever taken Coumadin, Warfarin or any other blood thinner?	□ Yes	□ No	If yes..
Do you use tobacco?	□ Yes	□ No	

Please mark any that apply *(Women only)*

□ Pregnant or trying to get pregnant	□ Nursing	□ Taking oral contraceptives

Are you allergic to any of the following?

□ Penicillin	□ Codeine	□ Acrylic	□ Latex
□ Sulfa drugs	□ Local anesthetics	□ Seasonal allergies	□ Other

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

AIDS/HIV Positive	□ Yes □ No	High Blood Pressure	□ Yes □ No	Cancer	□ Yes □ No	Sinus Trouble	□ Yes □ No
Anemia	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Chemotherapy	□ Yes □ No	Seasonal Allergies	□ Yes □ No
Hemophilia	□ Yes □ No	Heart Trouble/Disease	□ Yes □ No	Radiation Therapy	□ Yes □ No	Jaw Joint Pain	□ Yes □ No
Hepatitis B or C	□ Yes □ No	Congenital Heart Disorder	□ Yes □ No	Leukemia	□ Yes □ No	Fainting/Dizzy Spell	□ Yes □ No
Artificial Joint	□ Yes □ No	Artificial Heart Valve	□ Yes □ No	Lung Disease	□ Yes □ No	Epilepsy or Seizures	□ Yes □ No
Tuberculosis	□ Yes □ No	Pacemaker	□ Yes □ No	Emphysema/COPD	□ Yes □ No	Kidney/Liver Disease	□ Yes □ No
Thyroid Disease	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No	Asthma	□ Yes □ No	Ulcers	□ Yes □ No
Diabetes	□ Yes □ No	Stroke	□ Yes □ No	Alzheimer's Disease	□ Yes □ No	Osteoporosis	□ Yes □ No
Drug Addiction	□ Yes □ No	Psychiatric Care	□ Yes □ No				

Have you ever had any serious illness not list above	□ Yes	□ No	If yes..

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can affect dental care. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ **Date:**_____

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Financial Policies

Thank you for choosing Madison Ave Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. In order to enhance communication and promote understanding regarding our Financial Policies, please read through the following information.

Payment Options:

- Cash or Check
- Visa, Mastercard, Discover Card, and American Express
- No interest payment plans from CareCredit
- A pre-arranged in-office payment plan

Please note:

Our office requests payment in full on the day of service unless specific arrangements have been made in advance.

If you have insurance, we will submit the claim to your insurance carrier. Your estimated out of pocket will be due at the time of service. After insurance pays their portion, we will send a statement to you if there is any remaining amount unpaid by your insurance. It is the responsibility of the patient to know the plan benefits and limitations associated with their individual insurance plan. The patient is financially responsible for all charges, whether or not paid by insurance.

We may charge a 1.5% interest on all accounts that are 90 days past due.

A $20 fee may be assessed for any check returned by a bank.

There will be a $25.00 same day or 24hr notice cancellation fee

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

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HIPAA Acknowledgement & Authorization

I, _____, hereby acknowledge that I have been offered a copy of this dental practice's Notice of Privacy Practices. I further acknowledge that copy of the current notice will be available to me, upon request, at all subsequent appointments.

I authorize Madison Ave Dental, to disclose the information described below to the following individuals:

Recipient(s) of information:	**Name and Telephone Number**
☐ **Spouse**	_____
☐ **Child**	_____
☐ **Relative**	_____
☐ **Other**	_____

I authorize Madison Ave Dental to leave messages including dental, medical, and financial information:

- ☐ **Yes** **On my answering machine or voice mail.**
- ☐ **No** **I prefer that the dentist or staff speak to me or an authorized individual directly regarding this information.**

This authorization shall remain in effect until I contact Madison Ave Dental, in writing to revise this form.

_____ _____
Name of Patient (Or Guardian) **Date of Birth**

_____ _____
Signature of Patient (Or Guardian) **Date**