



MADISON AVE DENTAL  
*Family & Cosmetic Dentistry*

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



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## Financial Policy

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 with 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.

A \$35 fee may be assessed for any check returned by a bank

### **There will be a \$50 fee for any appointment canceled or rescheduled with less than 48 hours of notice.**

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

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Patient, Parent or Guardian Signature

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Date

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Patient Name (Please Print)



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## **NO SHOW & LATE CANCELLATION POLICY (\$50 CHARGE)**

Due to increased scheduling demands and in lieu of raising prices, we have implemented a stricter no show & late cancellation policy beginning 2024.

Showing up to your appointment is extremely important. Since that time has been reserved for your dental care, you must give a minimum of **48 hour notice** to reschedule or cancel your appointment. If proper notice is not given, this will result in a **\$50 charge**.

Missing your scheduled appointment hurts multiple people: yourself, the dentist, the team member responsible for your care, and other patients who could have potentially been seen at that time. With enough notice, we can provide care to others.

We understand that emergencies happen and may waive this fee for certain circumstances – however, this will be at our discretion. Please note, work and traffic issues do not constitute emergencies. Furthermore, if you are more than 10 minutes late to your appointment, we may be forced to reschedule. Multiple missed appointments could result in dismissal from care at our office.

We value our patients and their trust in us, and hope that we can continue to provide the best possible care we can. Thank you for your understanding and support!

***Kurush Savabi, DDS***