Service Agreement

INSURANCE POLICY

Our office is dedicated to providing you with the best dentistry available. Our goal is to treat you in the same manner we would treat our own family.

Please remember your insurance policy is a contract between you and your insurance company. We will gladly file your primary and secondary insurance claims, but ultimately you will be responsible for satisfying all balances with our office. If there is a problem in collecting from your insurance company, you will be responsible for resolving that problem and paying Tinsley Dentistry for any balance on your account.

In an effort to assist our patients, we verify dental insurance coverage, but like the insurance company themselves; we cannot guarantee payment or eligibility at the time of service. We will estimate your co-pay based upon the coverage information we are given. We ask you to pay this estimated co-pay when services are rendered.

CANCELLATION POLICY

We recognize how important your time is to you and we strive to schedule appointments that accommodate the scheduling needs of all our patients. In return we request that patients give adequate notice if unable to make your scheduled appointment. A twenty-four (24) hour notice is required in order to avoid a $55 charge for insufficient notice or failed appointments.

PATIENT INFORMATION AND MEDICAL HISTORIES

Please answer the patient registration and medical history questions to the best of your ability. This will enable us to provide you with the best treatments.

If you have any questions or concerns, please feel free to discuss them with us. We are glad you have chosen to become part of our thriving dental practice. We will strive to make your visit with us a unique and pleasant experience. Please sign and date below. We will make a copy for you to retain.

Sincerely,

Elisheva L. Tinsley, D.D.S.

_____ _____

Patient/Guardian Signature Date

PATIENT INFORMATION

Date _____ Age _____
Name _____ Nickname _____
Address _____
City _____ State _____ Zip _____
Phone (H) _____ (W) _____ Ext.____ Pager _____
Cell _____ E-Mail Address _____
Birth Date _____ Sex M F Marital Status S M D W
SSN# _____ Drivers License# _____
Spouse/Parent Name _____
Full Time Student? Y N School _____
Patient Occupation _____
Patient Employer _____
Employer Address _____
City _____ State _____ Zip _____

Responsible Party Info (person that carries the dental insurance)

Name _____
Birth Date _____ SSN# _____
Employer Name _____
Address _____ City _____ State _____ Zip _____
Phone _____ Ext _____ Phone _____

Insurance Information

Primary Insurance	Secondary Insurance
Insured Name _____	Insured Name _____
Birth Date _____	Birth Date _____
SSN# _____	SSN # _____
Insurance Co. _____	Insurance Co. _____
Address _____	Address _____
City _____ State __ Zip _____	City _____ State __ Zip _____
Group No. _____	Group No. _____
Phone No. _____	Phone # _____

Who may we thank for referring you? _____
Reason for visit? _____

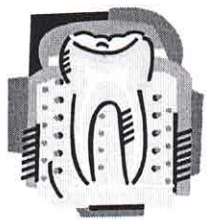
Consent for Treatment: This is to certify that I, Undersigned: (1) Consent to the performing of the Dental Procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated: (2) Consent to releasing information to my insurance company; and (3) Agree to pay the fees associated with the dental procedures, including the award of reasonable costs of collection agency fees (30%-50%) and attorney fees, at trial and on appeal, as determined by the court for the legal efforts necessary to obtain the fees.

_____ _____
Patient Signature Date Parent/Guardian Signature Date

Patient Name_____ Date_____

Medical Health History

Correct answers to the following questions will allow us to treat you on a more individual basis, providing the care appropriate for you particular needs.



Please answer each question. Circle Yes or No. If in doubt, leave blank.

1. Are you in good health now Y N
2. Are you now under the care of a physician Y N
   If so, what is the condition being treated _____
3. Have you ever been hospitalized Y N
   If yes, explain_____
4. Have you ever had excessive bleeding;
   Following an extraction Y N
   When getting cut Y N
5. Are you pregnant? If so, give due date Date _____ Y N
6. Do you use tobacco in any form Y N
   If yes how much:
   Cigarettes_____
   Cigars_____
   Pipe_____
   Snuff_____
   Chewing Tobacco_____
7. Do you use alcoholic beverages more than twice a day? Y N

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

GENERAL			**HEART/BLOOD VESSELS**		
Excessive thirst	Y	N	Rheumatic fever	Y	N
Tire easily, weakness	Y	N	Heart Murmur	Y	N
Marked weight change	Y	N	Chest pain/discomfort	Y	N
Night sweats	Y	N	Heart attack/trouble	Y	N
Persistant fever	Y	N	Shortness of breath	Y	N
SKIN			Swelling of ankles/hands	Y	N
Eruptions (rash) hives	Y	N	Abnormal blood pressure	Y	N
Change in skin color	Y	N	Congenital heart disease	Y	N
EYES			Artificial heart valve	Y	N
Visual Change	Y	N	Pacemaker	Y	N
Glaucoma	Y	N	Heart Surgery	Y	N
EARS			Other_____		
Loss of hearing	Y	N	**DIGESTIVE SYSTEM**		
Ringing in ears	Y	N	Liver disease	Y	N
NOSE			Hepatitis A	Y	N
Frequent nosebleeds	Y	N	Hepatitis B	Y	N
Sinus problems	Y	N	Non-A, Non-B Hepatitis	Y	N
THROAT			Jaundice	Y	N
Soreness/hoarseness	Y	N	Ulcers	Y	N
NERVOUS SYSTEM			Change in Appetite	Y	N
Stroke	Y	N	Black, bloody or pale stool	Y	N
Headaches	Y	N	**URINARY**		
Convulsions/epilepsy	Y	N	Kidney disease	Y	N
Numbness/tingling	Y	N	Increased urination	Y	N
Dizziness/fainting	Y	N	Burning during urination	Y	N
Psychiatric Treatment	Y	N			

Respiratory		
Tuberculosis	Y	N
Emphysema	Y	N
Asthma/Hay fever	Y	N
Persistent cough	Y	N
Sputum production (phlegm)	Y	N
Cough up bloody sputum	Y	N
Difficulty breathing lying down	Y	N
Allergies	Y	N
Mononucleosis	Y	N
Epstein/Barr	Y	N
Lung disease	Y	N
ENDOCRINE		
Diabetes	Y	N
Family history of diabetes	Y	N
Thyroid condition/goiter	Y	N
Parathyroid	Y	N
Hypoglycemia	Y	N
Bone/Muscles		
Arthritis/Rheumatism	Y	N
Artificial joints	Y	N
Gout	Y	N

Urethral discharge	Y	N
Bloody urine	Y	N
Venereal disease	Y	N
BLOOD		
Bruise easily	Y	N
Anemia	Y	N
Blood transfusion	Y	N
Date_____		
T cell count_____		
Viral Load_____		
HIV+	Y	N
Sickle cell anemia	Y	N
Hemophilia	Y	N
OTHER		
Radiation therapy	Y	N
Tumors or growths	Y	N
Cancer	Y	N
Chemo Therapy	Y	N
Cobalt	Y	N
Herpes	Y	N
Cold Sores	Y	N
Fever blisters	Y	N
Drug Addiction	Y	N

Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (Novocaine)	Y	N
Barbiturates/Sedatives/Sleeping pills	Y	N
Penicillin/other antibiotics	Y	N
Aspirin or Codeine	Y	N
Sulfa drugs	Y	N
Other allergies	_____	

Are you taking any of the following? (If yes to any, list the name of medication and dosage.)

Antibiotics/Sulfa drugs	Y	N	_____
Blood thinners	Y	N	_____
Blood pressure medication	Y	N	_____
Thyroid medication	Y	N	_____
Cortisone/Steroids	Y	N	_____
Antihistamines/allergy drugs	Y	N	_____
Cold remedies	Y	N	_____
Tranquilizers	Y	N	_____
Insulin/other diabetic drugs	Y	N	_____
Aspirin	Y	N	_____
Digitalis/other diabetic drugs	Y	N	_____
Nitroglycerin	Y	N	_____
Recreational drugs	Y	N	_____
Other medications	Y	N	_____

8. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain_____

_____

9. Medical Doctor's Name_____Phone #_____

Dental Treatment

10. Have you ever had any serious trouble associated with previous dental treatment? Y N
    If so, explain_____
    _____
11. Does dental treatment make you nervous? Y N
12. Date of last dental visit_____
13. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

14. Do you or have you ever had any of the following:

Bleeding/sore gums	Y	N	Loose teeth	Y	N
Unpleasant taste/bad breath	Y	N	Sensitive to hot	Y	N
Burning tongue/lips	Y	N	Sensitive to cold	Y	N
Frequent blisters, lips/mouth	Y	N	Sensitive to sweets	Y	N
Ortho treatment (braces)	Y	N	Sensitive to biting	Y	N
Biting cheeks/lips	Y	N	Food impaction	Y	N
Clicking/popping jaw	Y	N	Clenching/grinding	Y	N
Difficulty opening or closing	Y	N	Shifting of teeth	Y	N
Swelling/lumps in mouth	Y	N	Change in bite	Y	N

15. Oral Hygiene- Do you use the following?

Toothbrush	Y	N	How often do you brush?_____
Dental floss	Y	N	Brush is Soft___Med____Hard_____
Fluoride rinse	Y	N	How often do you floss?_____
			Floss is waxed_____unwaxed_____
			Brand name_____

Other Oral Hygiene Products you use:_____

16. If you could change anything about your smile, what would you change?_____
    _____

The information given about my health history in this form is accurate to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests (including x-rays) and evaluation of my dental health.

_____ _____
Signature of patient, parent or guardian Date

NAME OF OFFICE: Tinsley Dentistry
504 Sheridan Rd
Noblesville, IN 46060

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, _____, Date of Birth: _____, request that the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis(es), tests results, dates of service.

PLEASE CHECK ALL THAT APPLY

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

Name	Phone Number	Relationship

☐ You may leave Protected Health Information on my answering machine/voicemail.

☐ You may leave me a text message.
Phone Number: _____

☐ You may email me (unencrypted) for dental appointments.
Email Address: _____

☐ You may fax me for dental information.
Fax Number: _____

☐ Other: _____

☐ You may disclose insurance information to a referring dental office.

I have received a copy of this office's Notice of Privacy Practices.

_____ _____
Patient's Printed Name Social Security Number

_____ _____
Patient's Signature (or Guardian, if minor) Date