**TRAFALGAR FAMILY DENTISTRY, INC.**
*Jon A. Hendrickson, D.D.S.*

Phone: (317) 878-4990
Fax: (317) 878-9030

245 State Road 135 Trafalgar, IN 46181

# New Patient Checklist

Welcome to Trafalgar Family Dentistry and Orthodontics! We are happy that you have chosen us to assist you with your dental needs and in caring for your entire family.

## What to Expect

When you come in for your initial appointment our staff at the front desk will review the forms you have filled out and are happy to answer any additional questions you may have regarding estimating your patient paid portion (co-pay) that may be due that day, questions you may have regarding your insurance coverage amounts, covered procedures, or anything else that you may have questions about.

You are welcome to bring your children with you to your appointment. We have a kid friendly play section in the waiting area. Children can come back with you into the appointment rooms if necessary.

We feature pain free shots, nitrous oxide, and oral sedation dentistry for your comfort. While we understand that for some people there may be some anxiety about visiting the dentist, we do everything we can to make this a pleasurable experience. We want you to actually look forward to coming to the dentist's office.

## What to Bring

Download, complete, and print the New Patient Information Forms Pack. You can either fax these to our office in advance of your appointment or just bring them with you. Please don't forget to sign the forms.

In addition to these forms you should also bring:

- A list of any medications you are currently taking.
- Your dental insurance card.

## Cancellations

If for some reason you will not be able to be at your appointment, please give us at least a 24 hour notice so that we can give that time spot to another patient who may need it. You can call us directly or send an email to Cancellations@TrafalgarDentist.com. We will send you back confirmation that we received your message and reschedule your appointment for the next convenient time for you.

We look forward to serving you.

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# PATIENT INFORMATION FORM

Name _____ Birth Date _____

Address _____ City _____ Zip _____

Sex: ○ Male ○ Female Marital Status: ○ Minor ○ Single ○ Married ○ Divorced

Home Phone _____ Cell _____ Work _____

E-Mail _____ Emergency # _____

Drivers license # _____

## RESPONSIBLE PARTY INFORMATION

Name of person responsible for this account _____

Relationship to patient _____

Phone (if different from patient) _____

Nearest relative (not living with you) _____ Phone # _____

Nearest friend (not living with you) _____ Phone # _____

## INSURANCE INFORMATION

Name of insured _____ Birth Date _____

Employer _____ Work phone _____

Insurance Company _____ Social Sec# _____

Medicaid ID # _____

I will be paying for this bill TODAY with: ☐ Cash ☐ Credit/Debit ☐ Check

I understand that my full portion will be due when treatment is rendered. I understand that I will be responsible for all unpaid balances that the insurance has not paid within 90 days. I understand that failure to pay will result in the use of legal representation and that I will be responsible for all fees incurred. I also understand that if I am not able to attend a scheduled appt. I will give a 24 hr. notice. There will be a charge of $54.00 if you or a family member fails their appointment.

Signature_____ Date_____

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# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

## TRAFALGAR FAMILY DENTISTRY, INC.

I understand that, Under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third- party players
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a currant copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatments, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME _____

RELATIONSHIP TO PATIENT _____

SIGNATURE _____

DATE _____

## OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGE, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE: _____ INITIALS: _____

REASON _____

_____