

9291 East 109th Avenue - Crown Point, IN 46307

**WELCOME TO OUR PRACTICE!**

<b>1</b>			
DATE			
LAST NAME	FIRST	M.I.	
PREFERS TO BE CALLED BY	BIRTHDATE		
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.	CELL PHONE NO.		
EMAIL ADDRESS			
SOCIAL SECURITY NO.	BEST METHOD OF CONTACT		
CIRCLE ONE: SINGLE MARRIED DIVORCED WIDOWED			
DATE			
LAST NAME	FIRST	M.I.	
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.	EMAIL ADDRESS		
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL	GRADE		
SOCIAL SECURITY NO.	PREFERS TO BE CALLED BY		

IF THIS APPOINTMENT IS FOR YOU, START HERE.

IF THIS APPOINTMENT IS FOR YOUR CHILD, START HERE.

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO.

<b>2</b>	
DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

<b>4</b>		
ACCOUNT INFORMATION		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS	SOCIAL SECURITY NO.	
CITY		
PHONE NO.	STATE	ZIP
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS		
PHONE NO.		
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS		
PHONE NO.		

<b>3</b>		
GETTING TO KNOW YOU		
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

# Susan L. Royer, D.D.S.

## DENTAL HISTORY

Patient Name \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What kind of toothbrush do you use? Manual Toothbrush or Power Toothbrush

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

### Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? \_\_\_\_\_

### Do you:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleeping disorders? Yes No

Smoke/chew tobacco or use other tobacco products? Yes No

Get cold sores or canker sores? Yes No

Do you feel nervous about dental treatment? Yes No

If so, what is your biggest concern? \_\_\_\_\_

Have you had an upsetting dental experience? Please Yes No

describe \_\_\_\_\_

### Have you ever had:

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause Yes No

\_\_\_\_\_ Yes No

\_\_\_\_\_ Yes No

### Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neck aches, or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

**Are you satisfied with your teeth's appearance?** Yes No

Do you like the color of your teeth? Yes No

Are there old fillings or dental work you don't like looking at? \_\_\_\_\_ Yes No

Are all of your teeth in alignment? Yes No

Do you like the shape of your teeth? Yes No

What would you like to change the most in the appearance of your teeth? \_\_\_\_\_

\_\_\_\_\_

Have you ever been told to take a pre-medication antibiotic prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know about? Yes No

If yes, please describe \_\_\_\_\_

# Susan L. Royer, D.D.S.

## MEDICAL HISTORY

Patient Name \_\_\_\_\_

1. Physician's Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Have you had any medical care or been a patient in the hospital within the past five years?.....Yes No  
Describe \_\_\_\_\_
2. Have you taken any medication or drugs during the past two years?.....Yes No
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?.....Yes No  
If yes, please list name and dosage \_\_\_\_\_
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other similar drugs?.....Yes No
5. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcer	Yes	No	Hepatitis A B C (circle one)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S./H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Prolonged Bleeding	Yes	No
High/Low Blood Pressure	Yes	No	Anemia	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema or COPD	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic or Scarlet Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No	Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care	Yes	No
Kidney Trouble	Yes	No	Cancer or Tumors	Yes	No	Alcohol or Drug Addiction	Yes	No

6. Are you aware of having an allergic (or adverse) reaction to any substance or medication?.....Yes No  
If yes, please indicate by circling below:

Penicillin	Yes	No	Nitrous Oxide	Yes	No	Valium	Yes	No	Local Anesthetic (Novocaine or Xylocaine)	Yes	No
Erythromycin	Yes	No	Darvocet	Yes	No	Vicodin	Yes	No	Sleeping Pills (Nembutal or Seconal)	Yes	No
Tetracycline	Yes	No	Codeine	Yes	No	Aspirin	Yes	No	Scopolamine	Yes	No
Other Antibiotics	Yes	No	Demerol	Yes	No	Ibuprofen	Yes	No	Other		

7. Have you lost or gained more than 10 pounds in the past year?.....Yes No
8. Do you have or have you had any disease, condition, or problem not listed?.....Yes No  
If yes, please list: \_\_\_\_\_
9. **Women:** Are you pregnant or think you could be pregnant? Yes \_\_\_\_ Months No Nursing? Yes No
10. Do you use birth control prescriptions?.....Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### History Review

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_

# Susan L. Royer, DDS

## Office Policy and Informed Consent

Thank you for choosing us as your dental health care provider. We believe in the theories of modern dental care which do not support the old premise of only fixing it when it hurts. Through preventive care and regular checkups, many preventable treatments can be avoided. We are dedicated to your oral health and will make your visit as comfortable as possible. In return, we expect cooperation in making and keeping appointments.

- I authorize Susan L. Royer, D.D.S. and designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

**If patient is a minor:** I give permission for treatment to be performed whether or not I am present at the actual appointment, including but not limited to taking x-rays and administering anesthetics. YES / NO Phone number where I can be reached if necessary: \_\_\_\_\_ I understand that I am responsible to update this form, to keep phone number current, and make myself available during the dental procedures.

- Your insurance policy is a contract between you and that company. As a courtesy, we will file your insurance and accept assignment of insurance benefits on your first visit. We require 50% of that bill be paid at the first visit. Every insurance policy is different and it is impossible for us to know every policy exactly. We recommend you familiarize yourself with your own policy as some or all of your treatment may not be covered as part of your policy. Regardless, the charges incurred are your responsibility.
- Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. A 1.5% finance charge (18% annually) will be added to any balance over 30 days. A \$25 fee will be added to any account when a check is returned. In the unlikely event that your account remains unpaid, you will be responsible for all court costs, attorney fees, and collection fees.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent or Legal Guardian** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

### Release of Dental/Financial Information Consent

**YES / NO** I give permission to Susan L. Royer, D.D.S. and staff to disclose my current dental health and/or financial information, which may include but not limited to: dental conditions and treatment procedures, medication changes, financial or insurance assistance or plan of care to the following individuals for the purpose of assisting in my dental care or resolving insurance/account balances at my request or in the case of emergency only. This will remain in effect until rescinded in writing.

1. \_\_\_\_\_ 2. \_\_\_\_\_

Name Relationship to Patient Name Relationship to Patient

I give permission for my treatment and appointment details to be delivered in any of the following approved methods:

**YES / NO** Answering machine/voicemail

**YES / NO** By written correspondence - including open postcards at my address

**YES / NO** Email \_\_\_\_\_

**YES / NO** Fax # \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent or Legal Guardian** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

Susan L. Royer, D.D.S.

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\* You May Refuse to Sign This Acknowledgement \*

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

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but  
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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# NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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## **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 03/26/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Susan L. Royer, D.D.S.

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out 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 the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operation, of the uses and disclosures we may make of your 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 complete 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 changes. 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: Treatment Coordinator

Telephone: (219) 663-4024 Fax: (219) 663-0480

Email: info@susanroyerdds.com

Address: 9291 East 109<sup>th</sup> Avenue - Crown Point, IN 46307

**Right 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 affect any action we took in reliance on this Consent before we receive your revocation, and that we may 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 of your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_