SOUTHPORT DENTAL, P.C.
DOCTOR RYAN M. MILLS, DDS

DATE:_____**SSN**:_____**BIRTH DATE**:_____ **AGE**:_____

NAME:_____ **(MIDDLE INITIAL)**_____

HOME PHONE:_____ **CELL**:_____ **WORK**_____

ADDRESS:_____

CITY:_____ **STATE**:_____ **ZIP**:_____

EMAIL ADDRESS:_____

(PLEASE CIRCLE)
SEX: MALE FEMALE **STATUS**: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

EMPLOYER:_____**OCCUPATION**:_____

WHO CAN WE THANK FOR REFERING YOU?_____

IN CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT?
NAME:_____ PHONE:_____

*****IT IS IMPORTANT THAT WE ARE ABLE TO CONTACT YOU DURING OUR BUSINESS HOURS. AT WHICH NUMBER CAN WE EASILY REACH YOU**: CELL HOME BUSINESS OTHER:_____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT:_____

RELATIONSHIP TO PATIENT:_____**DATE BIRTH**:_____

SSN:_____ **ADDRESS**:_____

CITY:_____**STATE**:_____**ZIP**:_____**HOME #**:_____

RESPONSIBLE PARTY EMPLOYED BY:_____

INSURANCE COMPANY/ADDRESS:_____

SUBSCRIBER ID #:_____**GROUP #**:_____

ADDITIONAL INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT:_____

RELATIONSHIP TO PATIENT:_____**DATE BIRTH**:_____

SSN:_____ **ADDRESS**:_____

CITY:_____**STATE**:_____**ZIP**:_____**HOME #**:_____

RESPONSIBLE PARTY EMPLOYED BY:_____

INSURANCE COMPANY/ADDRESS:_____

SUBSCRIBER ID #:_____**GROUP #**:_____

DENTAL HISTORY

FORMER DENTIST:_____ DATE OF LAST X-RAY'S:_____

CITY, STATE:_____ HOW OFTEN DO YOU FLOSS?_____

DATE OF LAST DENTAL VISIT:_____ HOW OFTEN DO YOU BRUSH?_____

***PLEASE CHECK ALL THAT APPLY*:**

BAD BREATH…..... _____	LOOSE TEETH OR BROKEN FILLINGS_____	SENSITIVITY TO SWEETS.....____
BLEEDING GUMS…….____	ORTHODONTIC TREATMENT…..……..____	SENSITIVITY WHEN BITING.____
BLISTERS LIPS/MOUTH____	PAIN AROUND EAR……..____	FREQUENT HEADACHES…..____
FINGER NAIL BITING…____	PERIODONTAL TREATMENT…….____	JAW/HEAD/NECK INJURIES..____
GRINDING TEETH……____	SENSITIVITY TO COLD……____	JAW DIFICULTY:CLICK/PAIN____
LIP/CHECK BITING…..____	SENSITIVITY TO HEAT……____	TOOTH PAIN…….____

MEDICAL HISTORY

ARE YOU UNDER A PHYSICIAN'S CARE? WHAT FOR?_____
WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?_____
_____

HAVE YOU EVER BEEN TREATED FOR OR/ARE YOU TAKING MEDICATION FOR OSTEOPOROSIS OR ANY OTHER CONDITION RESULTING IN LOSS OF BONE DENSITY? YES NO

HAVE YOU EVER BEEN PRESCRIBED ANY OF THE FOLLOWING DRUGS: Fosamax, Boniva, Reclast, Prolia, Aredia or Zometa? _____

FAMILY PHYSICIAN:_____ PHONE NUMBER:_____
HAVE YOU EVER HAD A SERIOUS ILLNESS OR OPERATION?_____
DO YOU SMOKE? YES NO DO YOU USE ALCOHOL? YES NO

PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS/CONDITIONS THAT APPLY TO YOU:

___ AIDS
___ ALLERGIES (SEASONAL)
___ ANEMIA
___ ARTHRITIS
___ ARTIFICIAL HEART VALVE
___ ARTIFICIAL JOINTS
___ ASTHMA
___ BLOOD DISEASE
___ BRUISE EASILY
___ CANCER
___ CHEMOTHERAPY
___ CORTISONE MEDICATION
___ DIABETES
___ DIZZINESS
___ DRUG ADDICTION
___ EMPHYSEMA
___ EPILEPSY
___ EXCESSIVE BLEEDING
___ FAINTING
___ GLAUCOMA
___ HEART CONDITIONS
___ HEART LESIONS (CONGENITAL)
___ HEART MURMUR
___ HEART SURGERY
___ HEPATITIS A
___ HEPATITIS B
___ HEPATITIS C
___ HIGH BLOOD PRESSURE
___ HIV POSITIVE
___ HPV
___ JAUNDICE
___ JAW JOINT PAIN
___ KIDNEY DISEASE
___ LIVER DISEASE
___ LOW BLOOD PRESSURE
___ MITRAL VALVE PROLAPSE
___ NERVOUSNESS/DEPRESSION
___ PACEMAKER
___ PREGNANT CURRENTLY
___ RADIATION (HEAD/NECK)
___ RESPIRATORY PROBLEMS
___ RHEUMATIC FEVER
___ RHEUMATISM
___ SCARLET FEVER
___ SEIZURES
___ SINUS PROBLEMS
___ SLEEP APNEA
___ STOMACH PROBLEMS
___ STROKE
___ THYROID DISEASE
___ TUBERCULOSIS
___ ULCERS
___VENEREAL DISEASES
___ OTHER:_____
_____
_____
_____
_____

***ALLERGIC OR REACTED ADVERSELY TO ANY OF THE FOLLOWING*:**

___ ASPIRIN
___ NITROUS OXIDE
___ IODINE
___ LATEX
___ LOCAL ANESTHETIC
___ TETRACYCLINE
___ CODEINE
___ ERYTHROMYCIN
___ VALIUM
___ PENICILLIN
___SULFA
___ OTHER_____
_____
_____
_____

PERMISSIONS

I give my permission for Southport Dental, PC to discuss treatment, appointment dates and times and account information with the following:

Name/Relationship to Patient:

_____

_____

OFFICE POLICY

*Before treatment can be rendered, adequate radiographs of the teeth and mouth must be taken.

*Unless otherwise arranged, payment for professional service is required on the day the treatment is started. With prior approval, on certain extended procedures, payment plans can be arranged.

(Initial) _____

PERMISSION FOR TREATMENT AND PROMISE OF PAYMENT

Dental Insurance is a contract between my insurance company and me. I understand that Southport Dental, PC will submit all information to my insurance company as a courtesy to me. I agree to allow payment to be made directly to this office and realize that I am responsible for any charges that my insurance company does not cover. I agree to pay bill in a timely manner and will be responsible for all charges that are incurred in the collection of my account, including attorney fees, all billing charges, and 18% interest on overdue accounts.

Signed:_____ **Date**:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDEMENT

SOUTHPORT DENTAL, P.C.
7605 S EMERSON AVE
INDIANAPOLIS, IN 46237

I Understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 payers.
*Conduct normal healthcare operations such as quality assessment and physician certifications.

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 current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, 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.

Copies of HIPAA Notice of Privacy Acts are available upon request.

Patient Name: _____

Relationship to Patient:_____

Signature:_____

Date:_____

SOUTHPORT DENTAL, P.C.

Ryan M. Mills, DDS
7605 S Emerson Ave
Indianapolis, IN 4623
T:(317) 883-3300
F: (317) 889-3348

BROKEN APPOINTMENT/DISMISSAL POLICY

We have more patients who need dental care than we have room in our daily schedule to provide. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are unable to fill this appointment time with another patient who needs dental care. This policy is our attempt to ensure that both you and our other patients receive the dental care that you need.

Broken Appointments: Patients are only allowed **ONE** broken appointment in a 12-month time period.

Initial:

_____ Broken appointments are any time you are scheduled for an appointment and you do not show for that appointment.

_____ Late cancelations are considered broken appointment. If you need to cancel your appointment, we ask that you please call us at least **24 hours** before your appointment.

_____ Late arrivals are also considered broken appointments. If you do not arrive by 15 minutes after the start time of your appointment, it may be given to another patient. After 15 minutes of your appointment time, the appointment will need to be rescheduled.

Appointment Confirmations: You must call or reply text to confirm your appointment the business day before. Our practice closes at 5:00pm. It is **your responsibility to call/confirm**. If you do not call to confirm at least 24 hours before the start of your appointment, we will give your appointment away to another patient. This is considered a broken appointment.

*If for any reason, a patient misses their appointment or cancels late for a second time within a 12-month period, they will not be scheduled another appointment. However, these patients are still able to receive their dental care from us as a work-in patient. Patients who have broken two appointments with us can either call us in the morning for a "same day appointment" or they may come to our office as a "work-in patient" at 8am or 1pm. We always do our best to work our "work-in patients" into the schedule as long as it does not interfere with the care of previously scheduled patients; but please understand there is **no guarantee** that you will receive an appointment as a "work-in". Patients that break more than two appointments will be **dismissed** from our office and your current radiographs will be forwarded to the new Dentist of your choice.

Patient or Guardian Signature Date