



Joel Schoen, D.D.S.

D E N T A L
Smile Care Experts

Jeffrey Milne, D.D.S

Welcome to our practice. Please provide the information requested below as completely as possible.
If you have any questions, we'll be happy to help you.

PATIENT INFORMATION

Name _____
Last Name First Name Middle Name

Address _____

City _____ State _____ Zip code _____

Email Address _____

Home Phone _____ Mobile Phone _____

Work Phone _____ Ext _____ Fax _____

Employer Name _____ Occupation _____

Gender: Male Female Marital Status: Single Married Widowed Separated Divorced

Birth date _____ Age _____ Social Security Number _____

How would you like us to address you _____

Preferred Name

Preferred Method of contact: Home Phone Mobile Phone Work Phone Email Any method

If we cannot contact you by your preferred method, what other methods may we use to contact you? _____

Whom may we thank for referring you? _____

Whom should we contact in case of emergency? _____

Phone number of emergency contact _____

ACCOUNT INFORMATION

Person Responsible for account: Patient listed previously (Complete Insurance information and sign below)

Other (Someone other than the patient listed previously)

If other: _____
Last Name First Name Middle

Address (If different from patient) _____

City _____ State _____ Zip code _____

Email Address _____

Office
219-836-9122

www.whiteorchiddental.com
548 Ridge Road Munster, Indiana 46321

Fax
219-836-9123



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Home Phone _____ Mobile Phone _____

Work Phone _____ Ext _____ Relation to patient _____

PRIMARY INSURANCE INFORMATION

(If the patient has insurance coverage, please complete the information below)

Subscriber Name _____

Address (If different from patient) _____

City _____ State _____ Zip code _____

Birth date _____ Social Security Number _____ Relation to Patient _____

Insurance Company _____

Insurance Co. Phone Number _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Does the patient have additional insurance coverage? Yes No

ADDITIONAL INSURANCE

Subscriber Name _____

Address (If different from patient) _____

City _____ State _____ Zip code _____

Birth date _____ Social Security Number _____ Relation to Patient _____

Insurance Company _____ Insurance Co. Phone Number _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

AUTHORIZATION

I authorize the insurance company listed on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges. I understand that payment in full is due at the time of treatment, unless prior arrangements have been approved.

Signature _____ Date _____



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DENTAL HISTORY

Patient's name _____ Today's date _____

Patient's date of birth _____ Date of last dental cleaning _____

Previous dentist's name & phone number _____

Reason for the visit today: _____

Have you experienced any of the following problems? (Mark those that apply):

| | | | |
|------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Crooked teeth | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Tooth Pain |
| <input type="checkbox"/> Bad Taste | <input type="checkbox"/> Discolored teeth | <input type="checkbox"/> Lumps or bumps in mouth | <input type="checkbox"/> Do you wear dentures or partials? |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Food collecting between teeth | <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> Do you wear a nightguard? |
| <input type="checkbox"/> Broken fillings | <input type="checkbox"/> Grinding or clenching | <input type="checkbox"/> Sensitivity to heat | <input type="checkbox"/> Have you had trauma to the head or neck? |
| <input type="checkbox"/> Burning sensations in mouth | <input type="checkbox"/> Gum disease | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Do you smoke or chew tobacco? |
| <input type="checkbox"/> Chipped teeth | <input type="checkbox"/> Jaw pops or locks | <input type="checkbox"/> Sores in mouth | |

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure?

Yes No (If yes, please explain)

Have you had bad dental experiences in the past? Yes No (If yes, please explain)

If you could make changes to your smile, which of the following would you like to change?

| | | | |
|--------------------------------------------------------|------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Close spaces or gaps | <input type="checkbox"/> Make the smile whiter | <input type="checkbox"/> Make the smile straighter | <input type="checkbox"/> Reduce how much gum shows when I smile |
| <input type="checkbox"/> Remove silver / grey fillings | <input type="checkbox"/> Remove stains | <input type="checkbox"/> Replace old crowns | <input type="checkbox"/> Reshape teeth |

Other information about your dental health or previous treatment:

Signature _____ Date _____



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MEDICAL HISTORY

Patient's Name _____

Patient's Date of birth _____

Physician's name _____

Physician's Phone _____

Have you had any serious illnesses or operations? Yes No
If yes, please describe _____

Are you currently under physician's care? Yes No
If yes, please describe _____

Have you ever had a blood transfusion? Yes No
If yes, please give approximate dates: _____

Women: Are you pregnant? Yes No Are you nursing? Yes No Are you taking birth control? Yes No

Please check any of the following that apply to you:

| | | | |
|-----------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Herpes | <input type="checkbox"/> Respiratory treatment |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic/Scarlet fever |
| <input type="checkbox"/> Anaphylaxis (Life Threatening Allergy) | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Material allergies | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Swelling of feet, ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker/heart surgery | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Rapid weight gain, loss | <input type="checkbox"/> Ulcer/colitis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Venereal disease |

Are you allergic to any of the following medications? Penicillin Erythromycin Dental anesthesia
 Codeine Aspirin Hydrocodone (Vicodin) Sulfa

Allergies to other materials or medications _____

Current medications you are taking: _____

Do you pre-medicate for dental procedures? Yes No if yes, explain: _____

I have reviewed the information on this medical history and it is accurate to the best of my knowledge. I understand that this information will be used by White Orchid Dental, LLP to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Patient signature _____ Date _____

Dentist notes:

Dentist signature _____ Date _____

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OFFICE POLICY AND PAYMENT OPTIONS

The staff of White Orchid Dental is committed to providing outstanding dentistry. It is imperative that we continue to advance our skills in the art and science of quality care so that we may assure that you are experiencing the finest care modern dentistry offers. We need your assistance in helping us maintain this extraordinary level of care.

We request services be paid for at the time they are rendered. If you have dental insurance benefits, we will estimate your portion of each visit and ask that you pay the estimated out-of-pocket expense at each appointment. We accept cash, personal checks, Visa, MasterCard and Discover. We also offer financing with Care Credit. If this interests you, please ask us about the options available.

PAYMENT OPTIONS

Option 1 A full 5% savings for payments in full at time of service. (Cash, Check ,Visa, MasterCard or Discover)
If you have insurance, we will direct the insurance benefit to you.

Option 2 Pay as you go. Your estimated portion will be due at each appointment for services rendered that day.

Insured Patients only: Payment of estimated Co-payment will be due at each appointment for services rendered that day. Any remaining balance after insurance benefits have been provided, will be billed to you. If there is a credit balance, a re-imbusement check will be issued to you.

Option 3 Monthly Payment Options.

We offer a line of credit specially designed for the dental and medical fields known as CARE CREDIT. You can fill out the application form in our office or online (*no cost to apply or annual fees to be a member*) and receive immediate notice of approval. We offer interest free payment options. Longer payment plans are available with interest. (Entire estimated fee must be paid in full with Care Credit. If we receive, additional payments from your insurance carrier, we will provide a re-imbusement check to you.) Please review and sign the office policy agreement below. Feel free to ask any questions.

Returned checks and balances greater than 30 days will be subject to additional collection fees as well as interest charges of 1.5% per month (18% per annum). Responsible parties will be accountable for collection fees as well as any attorney and court fees associated with clearing the balance.

We will do our best to respect your time and we request you offer us the same courtesy. Missed appointments without advanced notice may be subject to charges or dismissal from our practice.

If you have any questions about your treatment, insurance benefits, or billing matters, please feel free to ask for clarification.

I understand and agree, regardless of my insurance status, I am ultimately responsible for any account balance. I also agree to responsibility for collection costs and attorney fees if my account is referred to collection.

I have read the information above and fully agree to the terms described.

Signature: _____

Date: _____

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HIPPA Notice of Privacy Practices

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THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE READ AND REVIEW CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, dental or mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the dentist/physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We will also disclose to a family member, spouse, adult children, and information as necessary for your overall dental care. By signing this document, you give permission to share your dental health information with any family member, friend or other persons to the extent necessary to help with your healthcare and/or with payment for your healthcare. For example: we would disclose your protected health information, as necessary, to a home health agency that provides care to you. An another example would be when we would need to share your records of information to a specialist or a physician to whom you have been referred to, to ensure that the physician or specialist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health/dental care services, including from your family members or friends. For example: obtaining approval for a dental procedure from an insurance carrier that may require that your relevant protected health information be disclosed to the insurance plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review, activities, training of medical/dental students, licensing, and conducting or arranging for other business activities. For example: we may disclose your protected health information to dental/hygiene students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment via mail or by phone.

We may use or disclose your protected health information in the following situations without your authorization: These situations include: as Required by Law, Public Health issues as required by Law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Your rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or

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administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

HIPPA Notice of Privacy Practices

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your physician/dentist is not required to agree to a restriction that you may request. If physician/dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician/dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. **We will not retaliate against you for filing a complaint.**

This notice was published and became affected on **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number 219-836-9122

I, _____, have received a copy of the above Notice of Privacy Practices from this office and give my permission to all of the above.

_____ Date: _____
Please Print Name

_____ Date: _____
Signature

***You may refuse to sign this acknowledgement*If refusing:**

_____ Date: _____
Signature