TODD WHITLOCK, DDS
3671 S. Sare Rd.
Bloomington, IN 47401
(812) 332-0052

Patient Information

Name ______________________________ Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Other

Date of Birth ______________ Age ________ SS# ______________

Home Address ______________________________

City ______________________ State ________ Zip ________

Email Address ______________________________

Home Phone ______________ Work Phone ______________ Ext. ________

Cell Phone ______________

Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Employer/School ______________ Occupation ______________

Employer Address ______________________________

City ______________________ State ________ Zip ________

Person Responsible for Account ______________ Phone ______________

Billing Address ______________________________

City ______________________ State ________ Zip ________

Spouse/Guardian's Name ______________ Employer ______________

Spouse/Guardian's Occupation ______________ Work Phone ______________

Please Share With Us...

How were you referred to our office?

☐ Family or Friend: ______________ ☐ Drive by/location ☐ BLOOM

☐ Website ☐ Facebook ☐ Google

☐ Doctor: ______________ ☐ Healthgrades

☐ Other: ______________ ☐ Radio

Previous Dentist ______________________ Date of last dental visit ______________

Your children's names and ages:

____

____

What will keep you as a long term patient in our practice?

____

____

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Insurance Information

Name of Insured ______________________ Date of Birth __________ SS # ______________

Insurance Co. Name ____

Phone ______________________

Name of Employer Group Plan ______________________ Policy # ______________________

Claim Filing Address ____

City______________________ State__________ Zip __________

- ☐ I authorize use of this form on all my insurance submissions.
- ☐ I authorize release of information to all my insurance carriers.
- ☐ I understand that I am responsible for my bill.
- ☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- ☐ I authorize payment directly to my doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.

Payment Options:
Please check preferred option:

- ☐ Visa/MasterCard
- ☐ Cash
- ☐ Check
- ☐ American Express
- ☐ Discover

Signature on File ______________________________ Date ______________

Consent: I grant authority to TODD WHITLOCK, D.D.S. to perform dental procedures and treatments that may be necessary.

Signature______________________________ **Date**______________

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MEDICAL HISTORY

PATIENT NAME:____ **DATE**:______________________

Have you had any of the following at any time?

YES	NO	
☐	☐	Cardiovascular Disease
☐	☐	Heart attack
☐	☐	Angina
☐	☐	Heart murmur
☐	☐	Pacemaker
☐	☐	Prosthetic heart valve
☐	☐	Congestive Heart Failure
☐	☐	Prosthetic joint implants
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Blood or bleeding problems
☐	☐	Stroke
☐	☐	Rheumatic fever
☐	☐	Skin problems, hives, or rashes
☐	☐	Thyroid Disease or Thyroid problems
☐	☐	Kidney Disease
☐	☐	Diabetes
☐	☐	Stomach problems or intestinal problems
☐	☐	Epilepsy
☐	☐	Fainting spells or seizures
☐	☐	Nervous condition
☐	☐	Fever blisters or cold sores
☐	☐	Sinus trouble
☐	☐	Arthritis
☐	☐	Osteoporosis
☐	☐	Hepatitis, Jaundice, or Liver Disease
☐	☐	Systemic Lupus
☐	☐	Rheumatoid arthritis
☐	☐	Emphysema/COPD
☐	☐	Asthma
☐	☐	Herpes
☐	☐	Venereal disease (gonorrhea, syphilis)
☐	☐	Glaucoma
☐	☐	Hearing Aid
☐	☐	AIDS or HIV infection
☐	☐	Tuberculosis
☐	☐	Cancer, Type and Treatment____
☐	☐	Alcoholism
☐	☐	Drug addiction
☐	☐	Tobacco habit
☐	☐	Seasonal Allergies (Hay fever)
☐	☐	Latex sensitivity or allergy
☐	☐	Are you allergic to any medications? Please List:_________________________________
☐	☐	Are you currently taking any medications (including aspirin)? Please List:________________________ ____
☐	☐	Are you currenlty or have you taken bone density medications? Please List drug name and dates taken:_________ ____
☐	☐	(Child) Are your immunizations current?
☐	☐	Are you in good health?
☐	☐	Are you pregnant?
☐	☐	Do you have any disease, condition, or problem not listed?____________________________ ____

Physician's Name:______________________________

Physician's Phone:______________________________

Physician's Address:___________________________

Pharmacy:____________________________________

If you could change anything about your smile, what would it be?

- ☐ younger
- ☐ lengthen teeth
- ☐ brighter
- ☐ close spaces
- ☐ replace missing teeth
- ☐ other: ____________________________
- ☐ cover stains
- ☐ shorten teeth
- ☐ straighten teeth
- ☐ repair chipped teeth

Please check any of the following conditions that apply to you.

- ☐ bad breath
- ☐ bleeding gums
- ☐ clicking or popping jaw
- ☐ food collection between teeth
- ☐ grinding teeth
- ☐ loose teeth or broken fillings
- ☐ periodontal treatment
- ☐ sensitivity to cold
- ☐ sensitivity to heat
- ☐ sensitivity to sweets
- ☐ sensitivity when biting
- ☐ sores or growths in your mouth

The above information is accurate to the best of my knowledge.

Patient Signature____

Todd Whitlock, D.D.S.
3671 S. Sare Rd.
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Patient:____ **Date:**____________________

Financial Options

In our office, we do not want money to be a problem for you. We want you to feel comfortable and satisfied with the financial arrangements regarding your dentistry. We encourage you to enter into a financial arrangement that is comfortable for you. For your ease and convenience, we offer several types of financial options.

1. **Payment in Full**
   Payment in full is required when treatment begins. For your convenience, we accept *Visa*, *Mastercard*, *Discover*, and *American Express* as well as, *cash* or *check*.

2. **Two Equal Payments**
   Payment may be divided into two equal payments for procedures that require more than one appointment. One half is to be paid on the day treatment begins; the remaining half is to be paid when treatment is complete.

3. **Care Credit Finance**
   The total fee may be paid in 12 months same as cash. Minimum amount of $300.00 and higher financed. Good credit standing required.

4. **Dental Insurance**
   Co-pay is required the day of service for all restorative, periodontal, and endodontic treatment.

I understand my dental insurance is a contract between the insurance carrier and me and not between Dr. Whitlock and the insurance carrier. Therefore, I am responsible for all dental treatment. Payments received by Dr. Whitlock from my insurance carrier will either be credited to my account or refunded to me if I have paid the dental fees incurred. I understand any fees not covered by insurance are the patient's responsibility.

I understand that if this account is referred to a collection agency, I am responsible for all collection fees, court costs, and attorney fees.

I accept option #____________ **to pay for my dental treatment.**

____ ______________________________

Patient's Signature **Date**