George A. Mighion, DDS, PC
Smile
Making first impressions memorable

Our Commitment to You.

Welcome to our office! We're very happy that you have chosen us be your dental provider. At our office we are committed not only to quality dental care, but also to our patient's valuable time. Because of this, we do not overbook the schedule and your appointment time is reserved exclusively for you.

We commit to respecting your time and in return, all we ask is that before you cancel or reschedule your appointment that you contact us two (2) business days prior to your scheduled time. Please keep in mind our business week is Monday through Thursday. ***All missed appointments with less than 2 business days' notice will incur a $25.00 fee.***

Thank you,

Dr. George A. Mighion

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home phone _____ Work phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____ ❑ **Phonebook**

❑ **Commercial** ❑ **Facebook** ❑ **Other (Please describe) _____**

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you ***allergic*** to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

Signature of patient (or parent) _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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}

For Office Use Only

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)

_____

PHOTOGRAPHY AGREEMENT and RELEASE

During your treatment Dr. Mighion will take some photos. Most of these pictures are used for planning your treatment and lab communication. They are also used to communicate with you about the appearance of your teeth so that the best possible result can be achieved.

Dr. Mighion would like to have your permission to use your photos for articles, advertisements, office brochures and educational purposes.

Please sign this agreement, which will give us your permission to use pictures of you and your bright new smile during your treatment process and some before and after shots. By signing this you are giving our office permission to use the photos for marketing purposes.

Thank you!

The Treatment Team and
George A. Mighion, D.D.S.

Patient Printed Name: _____

Signature: _____

Date: _____

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COORDINATION OF BENEFITS WORKSHEET

If you, or any of your dependents who are covered under any State of Indiana health plan, you must provide this information to our office to ensure health claims are correctly processed (examples include, Medicare and Medicaid).

If you have other insurance, you must also complete Sections A and C below. Please complete Section B **and** provide a copy of the insurance identification card from the other coverage plan.
You must return the completed COB Worksheet to our office at your earliest convenience **before your scheduled appointment.**

SECTION A
Member Name: _____ Social Security #: _____

I and/or my dependents **do NOT have** other group health insurance coverage. _____

I and/or my dependents **DO have other group health insurance coverage .** _____
(You must complete Section B indicating the other coverage).

SECTION B
Insurance Company Name: _____
Policy Holder Name: _____
Identification Number: _____ Group Number: _____
Effective Date: _____ Policy Type: Private Insurance _____ State Plan_____

Covered Persons Relationship:
_____ _____
_____ _____
_____ _____
_____ _____

SECTION C
It is my responsibility to ensure that accurate information is maintained and kept updated regarding my Dental insurance plans. This includes other coverage which has been added or terminated for any individuals covered under my account. I understand that failure to do so may result in my claims **not being paid** by my insurance provider and will then be my responsibility to pay my unpaid claims to the office of George A. Mighion, D.D.S., P.C. along with any late charges that may be added.

I certify the above information is accurate.

Member Signature: _____ Date: _____

Please click on save below to submit this form so that we may assist in expediting your claim.