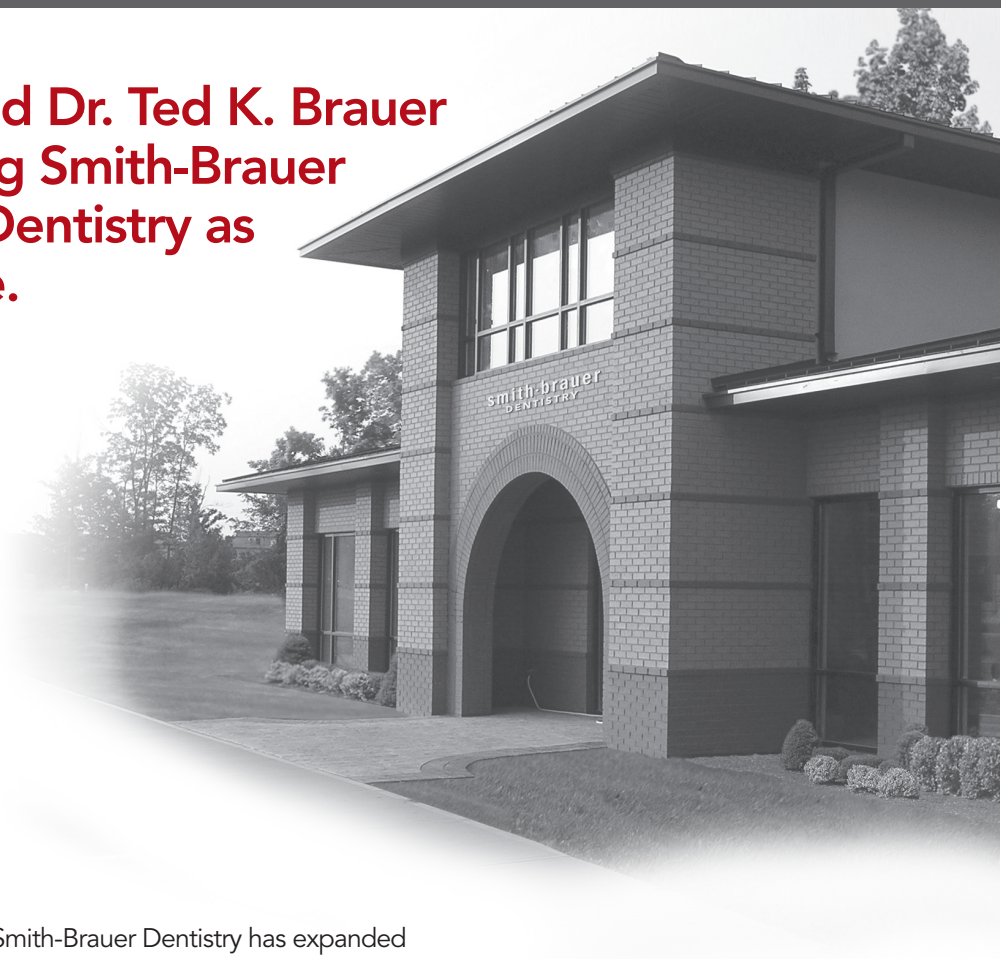
Dr. Harold A. Smith and Dr. Ted K. Brauer Thank You for choosing Smith-Brauer Family and Cosmetic Dentistry as your *new* dental home.



For over 40 years we have demonstrated our commitment to excellence in dentistry by serving our dental family with the most advanced care available, in a warm and friendly atmosphere.

- Our staff is of the highest caliber and have proven longevity in the field of dentistry
- We are committed to cutting edge, continuing education to ensure that you receive the best care available
- Our state-of-the art technology allows us to offer you exceptionally precise treatment plans for your dental health
- Our office is located conveniently for you at 8800 North on Allisonville Road, 5625 Castle Creek Parkway North Drive
- We accept most insurance plans, all major credit cards and offer comfortable payment options

Smith-Brauer Dentistry has expanded our vision to "give back" to our dental family and our community by opening the Smith-Brauer Center for Health and Wellness. We have partnered with the very best professionals and organizations committed to assisting others in becoming happier, healthier people. Our partners provide their time and services for you to relax, regenerate and enjoy at no cost to you. Not only are we reaching out to you, we are reaching out to non-profit organizations aligned with our vision to give back, so that we can all support each other's efforts as a community.

EXPERIENCE…
SMITH-BRAUER DENTISTRY IN TWO WONDERFUL WAYS!

Each month, we offer a calendar of special events focused on health enhancing activities at *no charge to you.* Services include:

- Health Screenings
- Quality of Life Workshops and Seminars
- Cooking Classes
- Massages
- Manicures and Pedicures
- Facials, Peels, and Microdermabrasion Treatments
- Arts and Crafts
- Special Clubs
- Training and meeting space for Non-profit and Health Care Organizations

REGISTRATION HISTORY — ADULT

PATIENT HISTORY

Today's Date _____

Name _____

Birth Date_____ Age _____ F___ M___

Marital Status _____ SS# _____

Home Address _____

City _____ ST_____ Zip _____

How Long? _____

Home Phone _____ Business Phone _____

Cell Phone _____ Email _____

Employer _____

Position _____ How Long? _____

Employer Address _____

_____

Name of Spouse_____

Spouse's SS# _____

Spouse's Employer_____

Position _____ How Long? _____

Spouse's Employer Address _____

_____

Phone _____

Name of Nearest Relative Not Living With You _____

_____

Phone _____

Whom may we thank for referring you?_____

THIS ACCOUNT WILL BE PAID BY

❑ CASH ❑ CHECK ❑ CREDIT CARD

❑ DEBIT CARD (PATIENT LIABILITY)

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR PAYING THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name_____

SS# _____

Birth Date_____ Age _____ F___ M___

Address _____

City _____ST _____ Zip _____

Phone _____

Responsible Party's Employer _____

Position _____ How Long?_____

Employer's Address _____

Employer's Phone_____

DENTAL INSURANCE INFORMATION

Subscriber's Name _____

Birth Date _____SS# _____

Subscriber's Employer _____

Employer's Address _____

Insurance Company _____

Address _____

Group No. _____

Have you used the dental insurance previously? ❑ Y ❑ N

SECONDARY INSURANCE INFORMATION

Subscriber's Name _____

Birth Date _____SS# _____

Subscriber's Employer _____

Address _____ Phone _____

Insurance Co. _____

Address _____

Group No. _____

I AUTHORIZE ALL OF THE ABOVE INFORMATION TO BE USED AS NEEDED BY SMITH-BRAUER DENTISTRY TO FACILITATE MY DENTAL TREATMENT. I AGREE TO ASSUME THE FINANCIAL RESPONSIBILITY FOR ALL DENTAL EXPENSES INCURRED. THE UNDERSIGNED AGREES THAT ALL PAST DUE ACOUNTS SHALL BE CHARGED A MONTHLY BILLING FEE ON THE UNPAID BALANCE COMMENCING THIRTY (30) DAYS AFTER BILLING. THE UNDERSIGNED SHALL ASSUME ALL RESPONSIBILITY FOR ALL COLLECTION AGENCY FEES CHARGED TO US, ATTORNEY FEES, COURT COSTS AND OTHER COST INCURRED WHILE COLLECTING THE AMOUNT DUE. I AGREE THAT ALL INFORMATION ON FRONT AND BACK IS TRUE AND CORRECT AND WILL INFORM THIS OFFICE OF ANY CHANGES.

SIGNATURE _____ **DATE** _____

RESPONSIBLE PARTY

ASSIGNMENT OF BENEFITS

I, _____ HEREBY ASSIGN ALL DENTAL BENEFITS TO SMITH-BRAUER DENTISTRY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE WITHIN 60 DAYS OF SERVICE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. THE UNDERSIGNED AGREES THAT ALL PAST DUE ACCOUNTS SHALL BE CHARGED A MONTHLY BILLING FEE ON THE UNPAID BALANCE COMMENCING THIRTY (30) DAYS AFTER BILLING. THE UNDERSIGNED SHALL ASSUME ALL RESPONSIBILITY FOR ALL COLLECTION AGENCY FEES CHARGED TO US, ATTORNEY FEES, COURT COSTS AND OTHER COST INCURRED WHILE COLLECTING THE AMOUNT DUE.

SIGNATURE _____ **DATE** _____

RESPONSIBLE PARTY

HEALTH HISTORY

General Health (Please Check): ❑ Good ❑ Fair ❑ Poor

Physician _____ Phone _____

Address_____

Are you presently taking any medicine or drugs? ❑ Y ❑ N

If yes, list drug, dosage, and frequency _____

_____

Allergic to Penicillin or any other drug? ❑ Y ❑ N

If yes, explain_____

_____

Ever been hospitalized in the past 5 years? ❑ Y ❑ N

Have any excessive bleeding when cut? ❑ Y ❑ N

(Women) Are you pregnant? ❑ Y ❑ N

If yes, how long? _____

(Women) Are you taking oral contraceptives? ❑ Y ❑ N

If yes, did you know that antibiotics can decrease the effectiveness of birth control pills? ❑ Y ❑ N

Circle any of the following you have had or have presently:

- ❑ Heart Condition
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Chest Pains (Angina)
- ❑ Heart Surgery
- ❑ Abnormal Blood Pressure
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Anemia or Hemophilia
- ❑ Bruise Easily
- ❑ Shortness of Breath
- ❑ Swelling of the Ankles
- ❑ Lung Disease
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Ulcers
- ❑ Skin Rashes or Hives
- ❑ Kidney Trouble
- ❑ Diabetes
- ❑ Sickle Cell Disease
- ❑ Liver Disease
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Yellow Jaundice
- ❑ Thyroid Disease
- ❑ Cortisone Medicine
- ❑ Glaucoma
- ❑ Arthritis or Rheumatism
- ❑ Alcoholism
- ❑ Drug Addiction
- ❑ Cancer or Tumor
- ❑ Venereal Diseases
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ HIV Positive/AIDS
- ❑ Genital Herpes
- ❑ Cold Sores
- ❑ Epilepsy or Seizures
- ❑ Psychiatric Treatment
- ❑ Artificial Joint
- ❑ Artificial Implants

DENTAL HISTORY

Date of last visit to a dentist _____

Dentist's name _____ Phone _____

Did you have x-rays taken? ❑ Y ❑ N

Have you had all your teeth x-rayed in the past 3 years? ❑ Y ❑ N

Do you wear full or partial dentures? ❑ Y ❑ N

If yes, how old are they? _____

Does any member of your family, including your parents, wear dentures? ❑ Y ❑ N

Have you had orthodontic treatment? ❑ Y ❑ N

Do you clench or grind your teeth during the day or night? ❑ Y ❑ N

Have you ever had pain in your jaw joint or your face (in or about your face)? ❑ Y ❑ N

Orthodontic appliances worn now or ever before? ❑ Y ❑ N

Does your jaw joint click or do you have difficulty opening your mouth widely? ❑ Y ❑ N

Do you have an unpleasant odor, or taste, in your mouth? ❑ Y ❑ N

Do your gums bleed when brushing? ❑ Y ❑ N

Have you had gum disease or pyorrhea? ❑ Y ❑ N

Is your mouth or teeth sensitive to:
Pressure: ❑ Y ❑ N Cold: ❑ Y ❑ N Hot: ❑ Y ❑ N

Do you or any member of your family snore? ❑ Y ❑ N

Does food catch between your teeth every time you eat? ❑ Y ❑ N

Are you dissatisfied with the appearance of your teeth? ❑ Y ❑ N

How can we help? _____

What is the main reason for your visit today? _____

_____

Please add anything you feel is important for the doctor to know: _____

_____

_____

PATIENT HISTORY

Today's Date _____
Child's Name _____
Nickname _____ Age _____
Birth Date _____ F___ M___
Home Address _____
City _____ ST _____ Zip _____
School _____ Grade _____
Father's Name _____
Mother's Name _____
Father Employed By _____
How Long? _____
Position _____
Father's Home Phone _____
Business Phone _____
Father's SS# _____
Mother Employed By _____
How Long? _____
Position _____
Mother's Home Phone _____
Business Phone _____
Mother's SS# _____
Whom may we thank for referring you? _____

THIS ACCOUNT WILL BE PAID BY
❑ CASH ❑ CHECK ❑ CREDIT CARD
❑ DEBIT CARD (PATIENT LIABILITY)

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR PAYING THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name _____
SS# _____
Birth Date _____ Age _____ F___ M___
Address _____
City _____ ST _____ Zip _____
Phone _____
Responsible Party's Employer _____
Position _____ How Long? _____
Employer's Address _____
Employer's Phone _____

DENTAL INSURANCE INFORMATION FOR CHILD

Subscriber's Name _____
Birth Date _____ SS# _____
Subscriber's Employer _____
Employer's Address _____
Insurance Company _____
Address _____
Group No. _____
Have you used the dental insurance previously? ❑ Y ❑ N
Is the child covered by more than one dental plan? ❑ Y ❑ N

SECONDARY INSURANCE INFORMATION

Subscriber's Name _____
Birth Date _____ SS# _____
Subscriber's Employer _____
Address _____ Phone _____
Insurance Co. _____
Address _____
Group No. _____

I authorize all of the above information to be used as needed by the dental office to facilitate this child's dental treatment. I understand that I am financially responsible for the dental expenses of this child. I understand that I am financially responsible for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing. The undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other cost incurred while collecting the amount due.

SIGNATURE _____ **DATE** _____
RESPONSIBLE PARTY

ASSIGNMENT OF BENEFITS

I, _____ hereby assign all dental benefits to Smith-Brauer Dentistry I understand that I am financially responsible for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing. The undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other cost incurred while collecting the amount due.

SIGNATURE _____ **DATE** _____
RESPONSIBLE PARTY

HEALTH HISTORY

Child's Physician _____

Phone _____

Date of Last Examination _____

Results _____

Is this child under the care of a physician now? ❑ Y ❑ N

Receiving any medication or drugs? ❑ Y ❑ N

Have any excessive bleeding when cut? ❑ Y ❑ N

Even been hospitalized? ❑ Y ❑ N

Allergic to Penicillin or any other drug? ❑ Y ❑ N

If yes, explain_____

_____

Does this child have any history of or difficulty with any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Asthma
- ❑ Bladder
- ❑ Cerebral Palsy
- ❑ Chicken Pox
- ❑ Chronic Sinus
- ❑ Convulsions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Hearing
- ❑ Heart
- ❑ Hepatitis
- ❑ Kidney
- ❑ Liver
- ❑ Malignancies
- ❑ Mastoid
- ❑ Measles
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Rheumatic Fever
- ❑ Thyroid
- ❑ Tuberculosis
- ❑ Other, Explain

Please describe any current treatment including drugs, pending surgery, recent injuries or any other information this office should be aware of. _____

_____

May we request release of this child's medical records for our reference? ❑ Y ❑ N

This information was given by _____

Relationship to child _____

DENTAL HISTORY

Date of last visit to a dentist _____

For what service? _____

Has child complained about dental problems? ❑ Y ❑ N

Explain _____

Any unhappy dental experiences? ❑ Y ❑ N

Explain _____

Any injuries to mouth – teeth – head? ❑ Y ❑ N

Explain _____

Any mouth habits – thumb sucking, nail biting, nursing bottle habits, pacifier, etc.? ❑ Y ❑ N

Explain _____

Any unusual speech habits? ❑ Y ❑ N

Explain _____

Any lost teeth? ❑ Y ❑ N

Explain _____

Have teeth been replaced? ❑ Y ❑ N

Explain _____

Orthodontic appliances worn now or before? ❑ Y ❑ N

Explain _____

Does your child brush teeth daily? ❑ Y ❑ N

Explain _____

Do you assist child with tooth brushing? ❑ Y ❑ N

How often? _____

Is dental floss used? ❑ Y ❑ N

How often? _____

Are disclosing tablets used? ❑ Y ❑ N

Is fluoride taken in any form? ❑ Y ❑ N

Child's attitude towards dentistry_____

_____

Do you desire complete dental service? ❑ Y ❑ N

Explain _____

SUMMARY (for doctor's use) _____

_____

_____

_____

PERIODONTAL DISEASE IS PAINLESS.

It affects 75% of the population and often victims are unaware. It may also affect your overall health. There are warning signs and the American Dental Association and our staff want you to be aware.

Do your gums bleed when you brush your teeth or toothpick between them?	❑ Yes	❑ No
Are your gums red, swollen, or tender?	❑ Yes	❑ No
Are your gums pulling away from your teeth?	❑ Yes	❑ No
Do you see pus between your teeth and your gums when the gums are pressed?	❑ Yes	❑ No
Are your permanent teeth loose and separating?	❑ Yes	❑ No
Is there any change in the way your teeth fit together when you bite?	❑ Yes	❑ No
Is there any change in the fit of your partial dentures?	❑ Yes	❑ No
Do you have persistent bad breath?	❑ Yes	❑ No

If the answer is yes to any of these questions, bring it to the attention of your dentist or hygienist.

ACT NOW AND KEEP YOUR TEETH FOR A LIFETIME!

What can we do in order to help you feel more comfortable during your time with us?

What do you want to accomplish during your appointment time with us during your initial visit?

What are you looking for in a dental office?

What concerns do you have about your teeth? Your smile? Your mouth?

Why did you leave your last dentist?

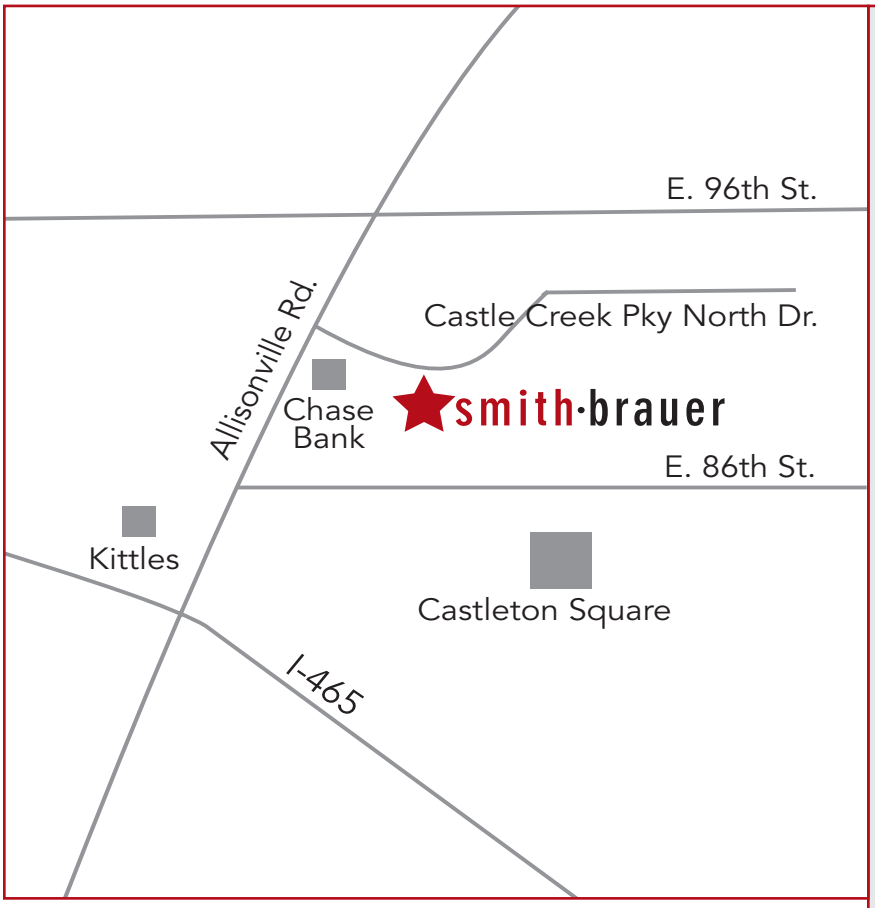
How long has it been since you've last seen a dentist?

Have you had unpleasant experiences?

Do your gums bleed when brushing or flossing?

Are you happy with the appearance of your smile?

Do you wish your teeth could be whiter?



DIRECTIONS TO SMITH-BRAUER DENTISTRY

Located at
8800 North on Allisonville Road
5625 Castle Creek Parkway North Drive
Indianapolis, IN 46250
317.585.0005
317.585.0006 F

smith-brauerdentistry.com

Directions from South, East and West

Take I-465 to the Allisonville Road Exit. Go north on Allisonville Road. (You will pass 86th Street and at the next stop light you will see a Chase Bank on the eastside.) At the light go east (turn right). We are the first building east of Chase Bank on Castle Creek Parkway North Drive.

Directions from the North

Take Allisonville Road south past 91st Street. At the next stoplight turn east (left) onto Castle Creek Parkway North Drive. We are the first building east of Chase Bank.

For assistance call:
317.585.0005