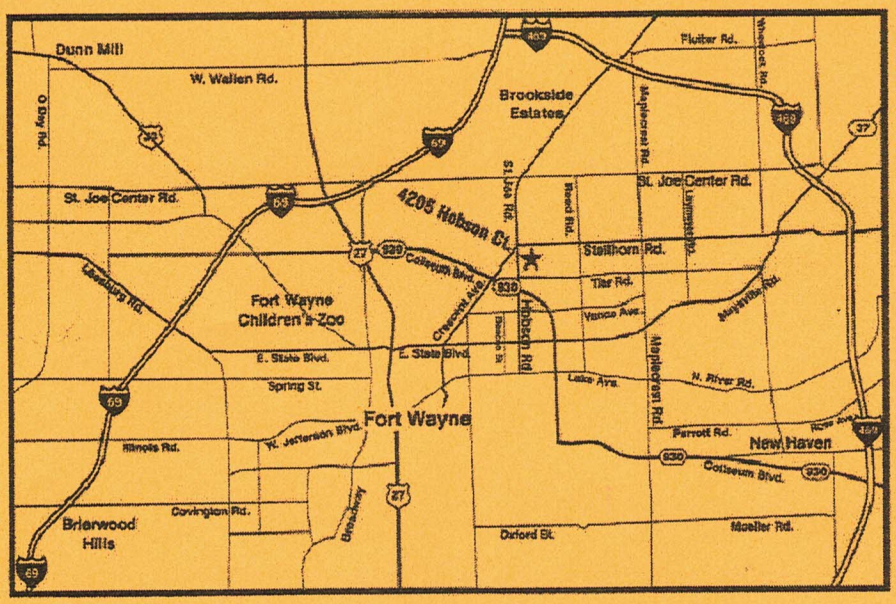
FORT WAYNE
PROSTHODONTICS

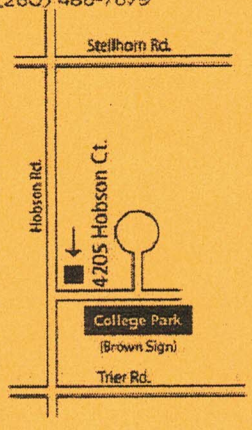
For your convenience, please find the enclosed forms to be completed, signed and returned at your scheduled appointment. **Consultation charge is $350.00 due at time of visit.** This includes the comprehensive exam and diagnostic models. Any necessary x-rays will be an additional fee
As a courtesy to you, if you have dental insurance, we will be happy to submit a claim on your behalf. Please bring your insurance cards to your appointment for duplication.

We look forward to seeing you on_____

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPT.



FORT WAYNE
PROSTHODONTICS
Ryan Zimmerman DMD, FACP
4205 Hobson Court
Fort Wayne, Indiana 46815-8648
Office: (260) 486-8778
Fax: (260) 486-7679



PATIENT INFORMATION

Date: _____

Please print:

Patient Information (CONFIDENTIAL)

Name_____Home #_____Cell#_____

If a child, Parent or Guardian Name_____

Address_____City_____State_____Zip Code_____

Date of Birth_____ Sex: ❑M ❑F Soc. Sec. No_____

Driver's License #: _____

Check appropriate box: ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Patient's Employer/School_____Work Phone_____

Email Address_____ Emergency Contact_____( ) -_____

Whom may we thank for referring you?_____

Reason for Visit?_____

Responsible Party (Ex: Parents, Spouse, Caregiver, Nursing home, P.O.A, etc.)

Name of person responsible for this account_____

Relationship to Patient _____Home Phone_____

Address_____

Soc. Sec. No._____ Birthdate_____

Employer_____Work phone_____

Is this person currently a patient in our office? ❑Yes ❑No

Insurance Information:

Name of Insured _____ Relationship to Patient_____

Subscriber's Birthdate_____Soc. Sec. No._____

Name of Employer _____Work Phone_____

Name of Insurance Co. _____Group No._____

Ins. Co. Address_____City_____State_____Zip code_____

Type of Insurance: Medical ☐ Dental ☐ Medicare ☐ Medicaid ☐

Do you have additional insurance? ❑Yes ❑No If yes complete the following:

Name of Insured _____ Relationship to Patient_____

Subscriber's Birthdate_____Soc. Sec. No._____

Name of Employer _____Work Phone_____

Name of Dental Insurance Co. _____Group No._____

Ins. Co. Address_____City_____State_____Zip code_____

Type of Insurance: Medical ☐ Dental ☐ Medicare ☐ Medicaid ☐

Medical History:

	Yes	No
1) Are you under medical treatment now?	❑	❑
2) Have you ever been hospitalized for any surgical operations or serious illness?	❑	❑
3) Are you taking any medication(s) **including non-prescription** medications?	❑	❑

If yes, please list **all** medications you are currently taking:

_____

_____

_____

Circle if you have ever taken:

Oral Bisphosphonates:
Fosamax Actonel Boniva Didronel Skelid Atelvia Bonefos/Loron Nerixia Olpadrontate

IV Bisphosphonates:
Aredia Zometa Reclast Aclasta

Non Bisphosphonate:
Xgeva Prolia Opdivo

	Yes	No
4) Do you use tobacco or vape?	❑	❑
5) Do you drink alcohol?	❑	❑
6) Do you take illegal drugs?	❑	❑
7) Do you take aspirin daily? ____mg	❑	❑
8) Please list any known allergies (Such as latex, sulfites, local anesthetics, antibiotics, sulfa drugs, iodine, aspirin, acrylics, metals, etc.):		

_____

_____

_____

_____

_____

	Yes	No
9) Does your jaw make noise or click when you open & close?	❑	❑
10) Do you ever have trouble opening widely?	❑	❑
11) Do people complain about you snoring or do you have sleep apnea?	❑	❑

Do you suffer from any of the following?

	Yes	No
Diabetes	❑	❑
High Blood Pressure	❑	❑
Heart attack	❑	❑
Low blood pressure	❑	❑
Heart disease	❑	❑
Chest Pain	❑	❑
Cardiac pacemaker	❑	❑
Heart Murmur	❑	❑
Rheumatic Fever	❑	❑
Fainting	❑	❑
Asthma	❑	❑
Epilepsy/Convulsions	❑	❑
Leukemia	❑	❑
Kidney Diseases	❑	❑
HIV/AIDS	❑	❑
Anemia	❑	❑
Emphysema	❑	❑
Cancer	❑	❑
Hepatitis	❑	❑
Liver Disease	❑	❑
Joint Replacement	❑	❑
Stroke	❑	❑
Tuberculosis	❑	❑
Seizures	❑	❑
Herpes	❑	❑
Mitral Valve Prolapse	❑	❑
Abnormal Bleeding	❑	❑
Frequent Headaches	❑	❑
Ulcers/Colitis	❑	❑
Persistent Cough	❑	❑
Venereal Disease	❑	❑
Psychiatric Treatment	❑	❑
TMJ Disorder	❑	❑

Please list any others:

_____

_____

_____

Name of Primary Medical Physician_____Phone:_____

Date of Last Medical Exam_____

Has there been any significant change in your health within the past five years which required you to be treated by a physician or to be hospitalized?_____

Please Explain _____

_____

Additional Medical History:

(Please circle to answer)

1)	Have your ever received Chemotherapy?	YES	NO
2)	Have you ever received radiation therapy?	YES	NO
3)	Have you ever been tested for HIV?	YES	NO
	If so, what were your test results at that time?	+	--
4)	Have you ever been tested for hepatitis?	YES	NO
	If so, what were the results at that time?	+	--
5)	Have you been tested recently for tuberculosis?	YES	NO
	If so, what were the results at that time?	+	--
	If so, was a chest x-ray taken at that time?	YES	NO
6)	Could you be pregnant	YES	NO

Dental History:

(Please circle to answer)

1)	Are your teeth sensitive to hot, cold, sweet or sour liquid/food?	YES	NO
2)	Do you feel pain in any of your teeth?	YES	NO
3)	Have you ever had difficult extractions in the past?	YES	NO
4)	Have you ever had prolonged bleeding following an extraction?	YES	NO
5)	Are you currently wearing dentures?	YES	NO
	Age of existing dentures:_____ years old		
6)	Date of last x-ray series is _____		
	How many were taken?_____		

Authorization and Release

I consent to be a patient at Fort Wayne Prosthodontics, Inc. and confirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the staff to perform the necessary services I may need. I agree to pay for services which I and the doctor agree to have rendered at the time of service. I understand that any insurance benefits will be assigned to me and that I am responsible to the doctor for payment of services. I authorize the release of any information necessary to process an insurance claim.

During the course of treatment, I may undergo procedures in all phases of dentistry, including periodontics (gum treatment), oral surgery, fixed and removable prosthodontics (crown, bridges, and dentures), Implant dentistry, restorative dentistry (such as fillings), oral pathology, cleanings, and radiography. I do voluntarily assume any and all possible risks, including the risk of substantial harm, risk of infection including COVID, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved.

I understand that my treatment plan may change at any time, and that I am welcome to ask questions about any aspect of my dental treatment and will request information if I am confused. I am responsible for clarifying any aspects of my treatment that I am unsure about. No guarantees can be made of treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including prosthodontics can involve unanticipated results.

Signature:_____Date:_____

FORT WAYNE
PROSTHODONTICS
Ryan Zimmerman DMD, FACP

CONSENT TO PHOTOGRAPHY

I, _____(Patient), authorize

Dr. Ryan Zimmerman to take photographs and/or videos of my face, jaws, teeth, eyes before, during and after treatment.

I consent to allow the photographs to be used for the following:

- ☐ *Dental and Medical Records (Required)*
- ☐ *Dental and Medical Research*
- ☐ *Dental and Medical Education including lectures, seminars, demonstrations, professional publications such as journals or books*
- ☐ *Marketing material, including websites and printed materials, patient education.*

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

- ☐ Check here if you do not want your *full-face* shot used for any of the above purposes.

Signature (Patient): _____Date: _____

4205 Hobson Court, Fort Wayne, Indiana 46815
phone: 260-486-8778 email: office@fortwaynepros.com

FORT WAYNE PROSTHODONTICS

Ryan Zimmerman DMD, FACP

Acknowledgment of Receipt of Notice of Privacy Practices
Effective Date of Revised Notice: February 16, 2026

Patient Name (printed) : _____ **Date of Birth:**_____

I acknowledge that I have been offered and/or received a copy of the Notice of Privacy Practices for **Fort Wayne Prosthodontics, Inc.**
The Notice of Privacy Practices explains how my medical and dental information may be used and disclosed for purposes of treatment, payment, and healthcare operations. It also describes my rights regarding my protected health information, including my right to:

- Inspect and copy my health information
- Request amendments to my health information
- Request restrictions on certain uses and disclosures
- Request confidential communications
- Receive an accounting of disclosures
- Obtain a paper copy of the Notice upon request
-

I understand that **Fort Wayne Prosthodontics, Inc.** reserves the right to change its Notice of Privacy Practices and that a current copy will be available in the office and upon request.

Authorization to Discuss My Health Information

I authorize **Fort Wayne Prosthodontics, Inc.** to discuss my protected health information with the following family members, friends, or other individuals:

Name	Relationship	Phone/Contact Info

I understand I may revoke this authorization at any time by notifying the office in writing.

Patient Signature: _____ **Date:**_____

If signed by personal representative, please indicate relationship to patient:

Relationship: _____
Printed Name of Personal Representative:_____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Patient refused to sign
☐ Patient unable to sign
☐ Emergency situation
☐ Other: _____

Staff Name: _____ **Date:**_____

4205 Hobson Court, Fort Wayne, Indiana 46815
phone: 260-486-8778 email: office@fortwaynepros.com

FORT WAYNE
PROSTHODONTICS
Ryan Zimmerman DMD, FACP

NOTICE OF PRIVACY PRACTICES

Fort Wayne Prosthodontics, Inc.
Effective Date: February 16, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

Fort Wayne Prosthodontics, Inc. is required by law to:

- Maintain the privacy and security of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of the Notice currently in effect
- Notify you without unreasonable delay, and no later than 60 days after discovery, if a breach of your unsecured PHI occurs

We reserve the right to change this Notice at any time. Any revised Notice will apply to all PHI we maintain and will be:

- Posted in our office
- Posted on our website
- Available upon request

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

1. Treatment

We may use and disclose your PHI to provide, coordinate, or manage your dental and prosthodontic care.
Examples include:

- Consulting with other dentists, specialists, physicians, or dental laboratories
- Sending prescriptions to pharmacies
- Referring you to other providers

2. Payment

We may use and disclose your PHI to obtain payment for services.
Examples include:

- Submitting claims to dental or medical insurance
- Verifying eligibility
- Billing and collections
- Providing information required by your insurer

3. Health Care Operations

We may use and disclose your PHI for operations necessary to run our practice, including:

- Quality assessment and improvement
- Staff training
- Licensing and accreditation
- Business management and administrative activities

4. Appointment Reminders and Communications

We may contact you for:

- Appointment reminders
- Treatment follow-up
- Information about services

We may contact you by phone, voicemail, text message, mail, or email unless you request alternative confidential communication methods.

5. Individuals Involved in Your Care
We may disclose relevant information to a family member, friend, or person involved in your care or payment, unless you object.

6. Required by Law
We will disclose PHI when required to do so by federal, state, or local law.

7. Public Health and Safety
We may disclose PHI for:

- Public health activities
- Reporting abuse or neglect
- Health oversight activities
- Judicial and administrative proceedings
- Law enforcement purposes
- To prevent a serious threat to health or safety

8. Workers' Compensation
We may disclose PHI as authorized by workers' compensation laws.

SPECIAL PROTECTIONS FOR REPRODUCTIVE HEALTH CARE
(2024 HIPAA Final Rule)
We are prohibited from using or disclosing PHI for the purpose of:

- Conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care; or
- Imposing criminal, civil, or administrative liability related to lawful reproductive health care.

In certain circumstances, before disclosing PHI potentially related to reproductive health care for law enforcement, judicial, or oversight purposes, we are required to obtain a signed attestation that the requested use or disclosure is not for a prohibited purpose.

SUBSTANCE USE INFORMATION
Any information in your record related to substance use or behavioral health conditions is treated as protected health information under HIPAA and applicable state law and will not be disclosed except as permitted or required by law.
Fort Wayne Prosthodontics, Inc. does not provide substance use disorder treatment services.

USES AND DISCLOSURES REQUIRING WRITTEN AUTHORIZATION
We will obtain your written authorization for:

- Uses or disclosures not otherwise described in this Notice
- Most uses of psychotherapy notes (if applicable)
- Marketing communications not related to treatment
- The sale of PHI

You may revoke your authorization in writing at any time.

YOUR RIGHTS
1. Right to Inspect and Obtain a Copy
You have the right to inspect and obtain a copy of your PHI in paper or electronic format.

- Requests must be made in writing.
- We will respond within 30 days of your request.
- We may charge a reasonable, cost-based fee as permitted by law.

2. Right to Amend
If you believe your PHI is incorrect or incomplete, you may request an amendment in writing.

We will respond within 60 days.

3. Right to an Accounting of Disclosures
You may request a list of certain disclosures made in the past six (6) years, excluding disclosures for treatment, payment, and health care operations.

4. Right to Request Restrictions
You may request restrictions on certain uses or disclosures of your PHI.
We are required to agree to a restriction request if:

- The disclosure is to a health plan for payment or operations, and
- The service was paid in full out-of-pocket.

Other restriction requests may be accepted but are not required.

5. Right to Request Confidential Communications
You may request that we contact you at a specific location or by specific means (for example, only at work or only by mail). We will accommodate reasonable requests.

6. Right to Receive a Paper Copy
You may request a paper copy of this Notice at any time, even if you agreed to receive it electronically.

7. Right to a Personal Representative
If you have designated a person to act on your behalf, such as through a medical power of attorney, health care representative designation, or legal guardianship, we will treat that person as your personal representative and allow them to exercise your rights regarding your protected health information, as permitted by law.
We may request documentation to verify the authority of the personal representative before releasing information.

BREACH NOTIFICATION
If a breach of unsecured PHI occurs, we will notify you without unreasonable delay and no later than 60 days after discovery of the breach, as required by federal law.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with:
Ryan Zimmerman
Security Officer
Fort Wayne Prosthodontics, Inc.
Phone: 260-486-8778
Email: office@fortwaynepros.com
You may also file a complaint with:
U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-877-696-6775
www.hhs.gov/hipaa/filing-a-complaint
You will not be retaliated against for filing a complaint.

CONTACT INFORMATION
For questions about this Notice or your privacy rights, contact:
Ryan Zimmerman
Security Officer
Fort Wayne Prosthodontics, Inc.
Phone: 260-486-8778
Email: office@fortwaynepros.com