

Chart #: _____
FOR OFFICE USE ONLY

Please review and correct prefilled information.

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies (list on last page) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> OTHER: (list on last page) |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Yes, I Use Tobacco |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> No, I Don't Use Tobacco |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |

• Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No Family Doctor Specialist

• Name of Physician: _____ Phone: _____

Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

• Preferred Pharmacy: _____
Name Location Phone

Emergency Contact Information

Name: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Mobile): _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice: _____

Spouse Information

Name: _____
 Male Female Married Single Other _____
Phone (Home): _____ (Work): _____ Ext: _____ (Mobile): _____
Address: _____
Street Apartment #
City State Zip Code

Responsible Party Information

The responsible party for payment is: The Patient The Person Responsible for Payment
Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Mobile): _____
Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Secondary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: «SIns Name»

Patient General Consent

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history. Please understand that a complete medical history is to assist you in your treatment and to allow the office staff to take proper protective measures for certain medical conditions.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

Medicaid patients understand that if their Medicaid coverage is suspended or terminated by Medicaid and Healthy Smiles Family Dental Care, PLLC is not reimbursed in full or part by Medicaid for your treatment, you, the patient, are financially responsible for the payment of your treatment in part or whole.

5. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
6. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
7. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.
8. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
9. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
10. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
11. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Patient or Guardian Signature

Date

Witness

Date

Healthy Smiles Family Dental Care, PLLC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Healthy Smiles Family Dental Care, PLLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Healthy Smiles Family Dental Care, PLLC** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Healthy Smiles Family Dental Care, PLLC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Terence Medley, Business Manager, 1927 Irvin Cobb Dr, Suite 1, Paducah, KY 42003**.

With this consent, **Healthy Smiles Family Dental Care, PLLC** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Healthy Smiles Family Dental Care, PLLC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Healthy Smiles Family Dental Care, PLLC** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Healthy Smiles Family Dental Care, PLLC** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Healthy Smiles Family Dental Care, PLLC** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Healthy Smiles Family Dental Care, PLLC** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print Name of Legal Guardian, if applicable

