FLOSS32 DENTISTRY

Brittany Lynn Holeman, DMD
Adam P. Weisenbarger, DDS

PATIENT INFORMATION FORM

Date: _____ How Did You Hear About Our Office?_____

Patient Information

Name:_____ Nickname:_____ Gender:_____ Marital Status:_____

Date of Birth: _____ Age: _____ SS#:_____

Address: _____ City: _____ State: _____ Zip Code:_____

Home: _____Work: _____ Cell: _____

Email Address: _____ Driver's License Info: _____

If Student, Name of School/College _____ City_____ State_____

Full-Time_____ Part-Time_____

Emergency Contact Information

Name:_____ Phone Number(s): _____

Responsible Party Information (if different than Patient Information)

Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home: _____ Work: _____ Cell: _____

Driver's License Information: _____ Employer: _____

Primary Dental Insurance Information

Insurance Company: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Subscriber Name: _____ Date of Birth: _____ SS#: _____

Employer: _____ Group Name: _____ Group #: _____

Subscriber/Member ID#: _____

Secondary Dental Insurance Information

Insurance Company: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Subscriber Name: _____ Date of Birth: _____ SS#: _____

Employer: _____ Group Name: _____ Group #: _____

Subscriber/Member ID#: _____

Patient Name:_____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.
*****If you are taking multiple medications, please provide a list.

Medical History

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you... Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? Latex Penicillin Codeine Sulfa Drugs Acrylic Local Anesthetics Aspirin Metal Other? _____

Do you use controlled substances? Yes No If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed? Yes No If yes _____

Dental History

Name of Previous Dentist and Location:_____ Date of Last Exam:_____

Do your gums bleed while brushing or flossing? Yes No

Are your teeth sensitive to hot or cold liquids/foods? Yes No

Are your teeth sensitive to sweet or sour liquids/foods? Yes No

Do you feel pain in any of your teeth? Yes No

Do you have any sores or lumps in or near your mouth? Yes No

Have you had any head, neck or jaw injuries? Yes No

Have you ever experienced any of the following problems in your jaw?

- Clicking? Yes No
- Pain (joint, ear, side of face) Yes No
- Difficulty in opening or closing? Yes No
- Difficulty in chewing? Yes No

Do you have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Do you bite your lips or cheeks frequently? Yes No

Have you ever had any difficult extractions in the past? Yes No

Have you ever had any prolonged bleeding following extractions? Yes No

Have you ever had orthodontic treatment (braces)? Yes No

Do you wear dentures or partials? Placement Date_____ Yes No

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No

Do you like your smile? If not, what would you change? Yes No

_____

****

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ **Date:** _____

FLOSS32 DENTISTRY

FINANCIAL & APPOINTMENT POLICIES

Welcome! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial and appointment policies.

FINANCIAL POLICY AND AGREEMENT:

Payment is expected at the time services are rendered. Our patients who have dental insurance are expected to pay their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, MasterCard or Discover. We also offer CARECREDIT, which is a financing option/extended payment plan that is available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance. Accounts that are over 90 days will incur a finance charge of 18% per annum, beginning August 1st 2017.

Optional payment terms and discounts*:

1. Prior Payment Courtesy: We offer a 5% accounting courtesy for all services over $250 that are paid in full at least 72 hours prior to the commencement of services.

2. Fee for Service Discount: We offer a 10% fee for service courtesy for our patients that are without dental insurance.

3. Veterans Discount: We offer a 20% courtesy for those that have served or are currently serving in the Armed forces. Proof of service is required.

4. Senior Citizen Courtesy: Anyone over the age of 60 may qualify for our senior citizen courtesy of 10% off services.

5. Financing Options: By arrangements with CARECREDIT we can offer patients upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee and no prepayment penalty. Ask for an application.

**Subject to terms and conditions, inquire at the office for details and exclusions.*

Insurance Information:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every insurance calendar year (your insurance year may not run January – December).

All of our doctors will diagnose treatment based on your dental health NOT your insurance coverage.

Treatment Plans:

Also as a courtesy to our patients, we will generate treatment plans stating the treatment recommended by the Doctors and the fee(s) associated with the treatment. If you have dental insurance we will include an *estimate* of how much your insurance is estimated to pay based upon the information they provide to us. The estimated portion not covered by your insurance will be due at the time of service. Please remember that we will strive to make this treatment plan as

accurate as possible, however, this is only an *estimate* and the portion covered by your insurance may be more or less than quoted. There may also be rare instances in which your insurance will not cover any portion of the recommended treatment. In this situation it will be the patient's responsibility to pay the associated treatment fees.

APPOINTMENT POLICY AND AGREEMENT

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 48 hour notice for any cancelled appointment.

Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 48 hour notice** will be considered a No Show and charged a **$25.00 fee**.

Any established patient who fails to show or cancels/reschedules an appointment without 48 hour notice a **second** time will be charged a **$50.00 fee**.

If a **third** No Show or cancellation/reschedule without 48 hour notice should occur the patient may be **dismissed** from the practice.

Any new patient who fails to show for their initial visit may not be rescheduled.

The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.

Saturday and Evening Appointments:

Because our most highly sought out appointments are **Saturdays and Evenings**, we have implemented a no show and cancellation policy for these coveted times.

If a patient does not show for a Saturday or an Evening appointment, we will no longer be able to schedule that person for a Saturday or evening appointment. The patient can be placed on a "short notice" call list and called if a time becomes available for our next scheduled Saturday or evening.

Because we try to confirm no less than 48 hours before the scheduled appointment, all Evening or Saturday appointments that are cancelled 48 hours before the appointment, the patient will receive one more opportunity to schedule and keep a Saturday or Evening appointment. At the time of the second occurrence, the patient can be placed on a "short notice" call list and called if a time becomes available for our next scheduled Saturday or Evening.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. This will be taken into consideration if or when it happens.

****

Please indicate your understanding and acceptance of these financial and appointment policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children (who are full-time students under the age of 25) who are patients of the practice.

_____

Patient's name (please print)

_____

Responsible Party's Signature **Date**

FLOSS32
DENTISTRY

8815 West Highway 22
Crestwood, KY 40014

I consent to be(or for my child to be) a patient at Floss 32 Dentistry 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), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder 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.

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 and deductibles according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for *any* costs that my insurance does not cover.

5. 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 Name (Please Print)

_____ _____
Patient OR Guardian Signature Date

_____ _____
Witness Date

FLOSS32 DENTISTRY

NOTIFICATION AND AUTHORIZATION FOR USE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Your insurance company(s), third-party payors, other healthcare providers and persons you indicate to have access to your appointment, account or clinical treatment information.

   May we phone, email, or send a text to you to confirm appointments? YES NO

   May we leave a message on your answering machine at home or on your cell phone? YES NO

2. The purpose for the release is at the request of the individual.
3. There is no expiration date for this authorization unless specifically requested by the patient.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you are covered by a dental insurance plan, you will be required to file your own insurance claims as this office will not be able to release any information to them.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

PATIENT or Guardian Signature_____ Date: _____

If you are signing as a personal representative or guardian of the patient, describe your relationship to the patient and/or the source of your authority to sign this form (i.e. parent, POA,etc.):

Print Name: _____

Source of Authority: _____

If there is anyone you would like to have access to your account or appointment information (including your spouse), please list their information below.

Name, Relationship and Phone Number of those who may have access to my appointment, account, and clinical treatment information:

_____ _____

_____ _____

☐ **I DECLINE TO SIGN THIS FORM.**