

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 Codeine Acrylic Aspirin Other? _____
 Penicillin Sulfa Drugs Local Anesthetics Metal _____

Do you use controlled substances? Yes No If yes _____

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No	Do you have frequent headaches? <input type="radio"/> Yes <input type="radio"/> No
Are your teeth sensitive to hot or cold liquids/foods? <input type="radio"/> Yes <input type="radio"/> No	Do you clench or grind your teeth? <input type="radio"/> Yes <input type="radio"/> No
Are your teeth sensitive to sweet or sour liquids/foods? <input type="radio"/> Yes <input type="radio"/> No	Do you bite your lips or cheeks frequently? <input type="radio"/> Yes <input type="radio"/> No
Do you feel pain in any of your teeth? <input type="radio"/> Yes <input type="radio"/> No	Have you ever had any difficult extractions in the past? <input type="radio"/> Yes <input type="radio"/> No
Do you have any sores or lumps in or near your mouth? <input type="radio"/> Yes <input type="radio"/> No	Have you ever had any prolonged bleeding following extractions? <input type="radio"/> Yes <input type="radio"/> No
Have you had any head, neck or jaw injuries? <input type="radio"/> Yes <input type="radio"/> No	Have you ever had orthodontic treatment (braces)? <input type="radio"/> Yes <input type="radio"/> No
Have you ever experienced any of the following problems in your jaw?	Do you wear dentures or partials? Placement Date _____ <input type="radio"/> Yes <input type="radio"/> No
Clicking? <input type="radio"/> Yes <input type="radio"/> No	Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="radio"/> Yes <input type="radio"/> No
Pain (joint, ear, side of face) <input type="radio"/> Yes <input type="radio"/> No	Do you like your smile? If not, what would you change? <input type="radio"/> Yes <input type="radio"/> No
Difficulty in opening or closing? <input type="radio"/> Yes <input type="radio"/> No	
Difficulty in chewing? <input type="radio"/> Yes <input type="radio"/> 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: _____



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



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



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.