Print Form

FAMILY CARE DENTISTRY

PATIENT INFORMATION

We appreciate the confidence you have placed in us to provide dental care to you. All information on this chart is necessary for our records and are strictly confidential.

Date: **Name:**			
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Social Security #:**	
Employer:	**Work Phone:**	**Date of Birth:**	
Email Address:			
Emergency Contact:	**Primary Phone:**		

POLICY HOLDER INFORMATION

Name:	**Social Security:**	**Date of Birth:**
Insurance Company:	**Insurance Policy #:**	**Insurance Group #:**

PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT (IF DIFFERENT THE POLICY HOLDER)

Name: **Primary Phone:**

How did you hear about our office? ☐ Radio ☐ TV ☐ Advertisement ☐ Visual ☐ Other ☐ Current Patient Referral:

DENTAL HEALTH INFORMATION

Please Check Yes or No

Are you having any discomfort?	**Yes** ☐ **No** ☐	Any sensitivity to hot, cold, sweets and/or chewing?	**Yes** ☐ **No** ☐
Do you smoke or use tobacco?	**Yes** ☐ **No** ☐	Does dental treatment make you nervous?	**Yes** ☐ **No** ☐
Do you drink tea or coffee?	**Yes** ☐ **No** ☐	Is the brightness of your teeth important to you?	**Yes** ☐ **No** ☐
Do you prefer to save your teeth?	**Yes** ☐ **No** ☐	Do you take a fluoride supplement?	**Yes** ☐ **No** ☐

Have you experienced any of the following?		**If I could change my smile I would make my teeth:**	
Bleeding Gums	**Yes** ☐ **No** ☐	Whiter	**Yes** ☐ **No** ☐
Bad Breath	**Yes** ☐ **No** ☐	Straighter	**Yes** ☐ **No** ☐
Soreness in jaw joint	**Yes** ☐ **No** ☐	Close Space	**Yes** ☐ **No** ☐
Grinding of teeth	**Yes** ☐ **No** ☐	Replace silver colored restorations	**Yes** ☐ **No** ☐
Snoring	**Yes** ☐ **No** ☐	Repair chipped teeth	**Yes** ☐ **No** ☐
Date of last cleaning:		Less Gum Showing	**Yes** ☐ **No** ☐
Date of last oral cancer screening:		Replace old crowns that don't match	**Yes** ☐ **No** ☐

What is the most important thing to you about your dental visit today?

What is the most important thing to you about your future smile and dental health?

FAMILY CARE DENTISTRY

Medical History

PATIENT NAME: **DATE OF BIRTH:**

Although dental personnel treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you under a physicians care now? ☐ **Yes** ☐ **No**
If yes, please explain.

Have you ever been hospitalized or had a major operation? ☐ **Yes** ☐ **No**
If yes, please explain.

Have you ever has a serious head or neck injury? ☐ **Yes** ☐ **No**
If yes, please explain.

Are you taking and medication, pills or drugs? ☐ **Yes** ☐ **No**
If yes, please explain.

Are you allergic to any of the following? ☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Local Anesthetics** ☐ **Acrylic** ☐ **Metal** ☐ **Latex** ☐ **Other** **If yes, please explain**

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

AIDS/HIV Positive	Yes ☐	No ☐	Cortisone Medication	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 Pressures**	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/Intesttinal Disease**	Yes ☐	No ☐
Breathing Problem	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 Valves 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 ☐	**Venereal Disease**	Yes ☐	No ☐
Convulsions	Yes ☐	No ☐	Heart Trouble Disease	Yes ☐	No ☐	**Psychiatric Care**	Yes ☐	No ☐	**Yellow Jaundice**	Yes ☐	No ☐

Have you had any other serious illness not listed above?

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 **DATE:**

FAMILY CARE DENTISTRY

FINANCIAL AND OFFICE POLICIES

As a courtesy we will file dental insurance claims for our patients. This does not transfer your financial obligation to your insurance company. If your insurance plan has a co-payment, you are required, per the contract signed with your insurance company, to pay that co-payment at the time of your visit. However, this does not guarantee that your insurance will pay the balance. If your claim is not paid, and you feel it should have been, please contact your insurance company directly.

We place tooth-colored fillings. If your insurance only allows Amalgam coverage, you will be responsible for any amount insurance does not cover for the difference in price between amalgam and tooth-colored fillings.

Missed Appointment Fee: The second time a patient does not show for an appointment, or cancels with less than a 24 hour notice, a $35.00 fee will be charged. This fee must be paid for by paid before any new appointments are scheduled.

Insufficient Funds Fee: In the event a check issued to Family Care Dentistry is returned for insufficient funds, a $35.00 fee will be charged in addition to the balance and will need to be paid in full with cash, money order or certified check.

In an effort to serve you better, we would like to send emails to you regarding your appointments and as a means of communication with you.

I understand and accept the above policies for myself and/or minor children.

Signature: **Date:**

FAMILY CARE DENTISTRY INFORMED CONSENT

DRUGS AND MEDICATIONS: I understand that analgesics, anesthetics, and other medications can cause allergic reactions resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe reactions. I have informed the doctor and/or staff of any known allergies. Certain medication may cause drowsiness and it is advisable not to drive or operate machinery when using such drugs.

RISKS OF ANESTHESIA: I understand that pain, bruising, and occasional temporary and sometimes permanent numbness in the lips, cheeks, tongue and associated facial structure can occur with injections ("shots"). About 90% of these cases resolve themselves in less than 8 weeks. Although rarely needed, a referral to a specialist for evaluation and possible treatment may be needed of the symptoms do not resolve and any costs thus incurred are my responsibility.

FILLINGS: I understand that a more extensive restoration than originally planned, or possibly root canal therapy may be required if additional conditions are discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

CROWNS, BRIDGES, INLAYS & ONLAYS: I understand that sometimes it is not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify the office of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc of a crown must be made prior to final fabrication and cementation. It is my responsibility to return to the office for final cementation of the restoration. I understand I may need further treatment and even by a specialist if complications arise during treatment and any costs thus incurred are my responsibility.

PERIODONTAL DISEASE: Periodontal disease can be a serious condition causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to follow my doctor's instructions, including strict observance or recall appointments. I understand that care by a specialist may be necessary.

CHANGES OF TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. The doctor and/or staff will discuss with me and I authorize my doctor to use professional judgment to provide appropriate care.

REFERRALS: I understand that it is sometimes necessary for me to be referred to a specialist or other healthcare provider in the event my healthcare would be better served elsewhere. I understand that I would be subject to the fees incurred by the referred provider and that it is my responsibility to speak with the provider to which I have been referred regarding their fees or my financial responsibilities.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantee have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all of my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

Signature: **Date:**

HIPAA Notice of Private Practice

Family Care Dentistry
13320 Shelbyville Road
Louisville, KY 40223
502.245.8494

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you may have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations : We may use or disclose, as needed, your protected health information in order to support our business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration Requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors: and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will Be Made Only With Your Consent, Authorizatin or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have a right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mailing of changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against your for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any obligations to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Permission to Share Medical/Dental or Account Information:
My Medical/Dental or Account Information may be obtained and exchanged verbally to the following person(s).

Name(s):
(If none, please leave blank)

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:

Signature: Date: