# DENTISTRY

We would like to say thank you for selecting our dental team! So that we may better serve you, please provide or update this information for us. This practice is HIPPA compliant and all information is secured for treatment and insurance purpose only. Your thoroughness is greatly appreciated.

## Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender:: _____ Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone or Pager: _____

Address: _____
Street Apartment # E-MAIL ADDRESS
City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

## Health Information

Date of Last Dental Cleaning: _____ Reason for today's visit: _____

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

**MEDICAL HISTORY**
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness / Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Growths / Tumors
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur / MVP
- ☐ Hepatitis / Jaundice
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Health Issues
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Venereal Disease

**DRUG ALLERGIES**
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other_____

**WOMEN**
- ☐ Are you pregnant?

Due Date:_____
- ☐ Are you nursing?
- ☐ Are you taking birth control?

**Dental History**
- ☐ Bite/ Chew Nails
- ☐ Biteguard Therapy
- ☐ Bleeding Gums
- ☐ Bleaching Treatment
- ☐ Blisters/ Sores on Lips
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Clench/ Grind Teeth
- ☐ Gums swollen or tender
- ☐ Jaw Pain or tiredness
- ☐ Loose teeth or broken fillings
- ☐ Mouth Breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold, heat or sweets
- ☐ Wisdom teeth removed

How often do you floss?
_____

How often do you brush?
_____

- Do you take antibiotics for dental appointments?_____If so what antibiotic do you take:_____
- Are you taking Coumadin or other blood thinners? ☐ Yes ☐ No
- 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
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
  ☐ Prescribed Medications and over the counter medications: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

## Responsible Party Information

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone or Pager: _____

Address: _____

Street Apartment #

City State Zip Code **E-MAIL ADDRESS**

Responsible Party
Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

## Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

Name of person or office referring you to our practice:

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

## Consent for Services

I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If there is any change in my medical status, I will inform the dentist. I understand that this information will be used by my dentist to help determine appropriate and healthful dental treatment. 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. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me during the period of such care to third party payers and/ or other health practitioners.

_____ Date: _____ Relationship to Patient: _____

Signature of Patient, or guardian

TLC DENTISTRY

3070 HARRODSBURG ROAD
SUITE 100
LEXINGTON KY 40503
859-223-8987

# IMPORTANT DENTAL INSURANCE INFORMATION FOR OUR PATIENTS

Understanding dental insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients who use many different companies. Each company pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different in covered services. It is **your** responsibility to become familiar with your policy exclusions, deductibles and required co-payments.

## OUR COURTESY SERVICE TO YOU INCLUDES:

1. Electronically filing your insurance within 24 hours of your visit and requesting payment of your benefits to our office.
2. Verifying benefits that are available to you.
3. Resubmitting your insurance claim a second time within 30 days if it has not been paid.
4. Following the American Dental Association guidelines for coding procedures and filing insurances.

## OUR EXPECTATIONS OF YOU AS THE OWNER OF THE POLICY:

1. **To provide us with a copy of your insurance card and the most current insurance information.**
2. Payment of fees NOT covered by your insurance plan at the time the service is delivered.
3. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
4. Realizing that dental insurance policies restrict payment for some services, some restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
5. Taking responsibility for payment if the insurance company does not pay our office within 60 days.
6. Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please sign the space below and have your insurance card ready for us to copy for our file.

**I hereby authorize TLC Dentistry, P.S.C. to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to TLC Dentistry, PSC. I understand I am responsible for any unpaid balance and any fees involved in collection efforts.**

_____ _____

Signature of Patient/Insured Date

TLC DENTISTRY

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

***Health Insurance Portability Accountability Act (HIPAA), 1996***

*http://www.hhs.gov/ocr/hipaa/finalreg.html*

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name:
Address:
Telephone: E-mail:
Social Security #:

**SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
TLC DENTISTRY 3070 Harrodsburg Road Lexington, KY 40503-2764 (859)223-8987

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Signature:** _____ **Date:** _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Acknowledgement of Receipt
Notice of Privacy Practices
Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records.
HIPAA web-site: **http://www.hhs.gov/ocr/hipaa/finalreg.html**

**You May Refuse to Sign This Acknowledgement***

I, T Test , have received acknowledgement of this office's Notice of Privacy Practices.

_____ June 19, 2014
**Signature**

**For Office Use:**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
☐☐ ____ Individual refused to sign
☐☐ ____ Communications barriers prohibited obtaining the acknowledgement
☐☐ ____ An emergency situation prevented us from obtaining acknowledgement
☐☐ ____ Other (Please Specify)