Welcome

Thank youfor choosing our pra ctice. Please}ill out thisf orm as completely as you can. If you have any questions we 'll be glad to help. (Please print)

Family Dental Center (Dr. Peters, PSC) 1006 Leawood DR. suite 200, Frankfort KY. 40601 502-223-0211

Patient information

First _____ Ml _____ Last _____

[ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: _____

Address _____ Occupation: _____ _____ [ ] Male [ ] Female

City _____ State _____ Zip _____ Hm# (__J _____

Employer _____ Wk# (__J _____ Ext _____

Are you: [ ] Minor [ ]Married [ ]Single [ ]Divorced [ ]Widowed [ ]Separated Cell # L_) _____

DOB: ___/_____/_____ SSN# _____ E-mail _____ @_____

Spouse's Name _____ What phone to call to confirm and leave message: _____

First Ml Last (if different)

Spouse occupation _____ Work phone _____ Ext _____

Is patient a full time student? [ ]No [ ]Yes:Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____

First MI Last

Address _____

City _____ State _____ Zip _____

Hm# (__J _____

Wk# (__J _____

DOB: ____/_____/_____

SSN# _____

Relationship: _____

About Dr.Peters:
D.M.D from University of Louisville
Member of American Society of Dental Anesthesia, Fellow ICOI
Fellow of Misch Institute, Alumni of Dawson Academy
ADA member, AEGD MEMBER, KDA member
Member of AES, member of American Academy of Cosmetic dentist

YOUR PREFERENCES

Do you prefer appointment reminders by: [ ] Email [ ] Phone [ ] Text

Do you prefer to receive calls from our office at: [ ] Home [ ] Work [ ] Cell

Whom may we thank for referring you?

How do you wish to be addressed by our staff?

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____

DOB: _____ Subscriber's SSN# _____ Insurance Co. phone # _____

Insurance Company _____ Member ID _____ Policy # _____

Group# _____

DENTAL INSURANCE:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State ____ Zip _____

DOB: __ / __ SSN# _____ Employer: Member ID _____

Insurance Company _____ Group # Eff. Date: ___/___/_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE?] Yes [ ] No Ifyes, please complete the following:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: /___/__SSN# _____ Employer: Member ID _____

Insurance Company _____ Group # Eff. Date: _/_/ ____

[Type text]

Family Dental Center uses the latest in dental imaging *Ct* scanner to plan for optiinuin dental treatment

CONFIDENTIAL

"Our practice is dedicated for a smile for a lifetime."
D. Patrick Peters D.M.D and Associates

Medical History

Although dental personnel treat the area In and around your mouth, your mouth Is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important Interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies

Acrylics Y N
Anaphalaxis (severe allergic reaction) y N
Latex y N
Local Anesthetics y N
Penicillin y N
Metal y N
Sulpha y N
Other y N
List other known allergies :

_____
_____
_____
_____

Cardiovascular

Artificial Heart Valve Y N
Coronary Artery Disease Y N
Chest Pain or Angina Y N
Congestive Heart Failure Y N
Heart Attack Y N
Heart Munnur Y N
High Blood Pressure Y N
High Cholesterol Y N
Irregular Heart Beat Y N
Low Blood Pressure Y N
Mitra! Valve Prolapse Y N
Pacemaker Y N
Tachycardia (fast heart rate) Y N

Endocrine

Diabetes Y N
Go Y N
Hormonal Change Y N
Thyroid problems Y N
Pregnant Y N

Eyes; Ea rs, Nose and Throat

Change in Hearing Y N
Change in Vision Y N
Dysphagia Y N
Ear Pain Y N
Glaucoma Y N
Hay Fever Y N
Nasal Obstruction Y N
Nose Bleeding Y N
Sinus Problems Y N
Tonsillectomy Y N
Tinnitus(ringing in ears) Y N

Gastrointestinal

Acid Reflux y N
GERD y N
Soft or Special Diet y N
Ulcers y N

Genitourinary

Frequent Urination Y N
Kidney disease Y N
Nocturia (urination at night) Y N

General

Current weight: lbs
Height: ft_____in
Cancer Y N
Fatigue/Tired Y N
General Weakness Y N
Headaches Y N
HIV/AIDS Y N
Knee/hip replacement Y N
Liver problems Y N
Recent Trauma or Injury Y N
Rheumatic Fever Y N
Radiation Treatment Y N
Weight Change Y N

Hematological

Bleeding problems y N
Hepatitis y N

Oral

Bleeding gums Y N
Dry mouth Y N
Jaw problems (TMJ)? YN
Clicking? Y N
Pain? Y N
Difficulty swallowing? Y N.
Difficulty chewing? Y N
Orthodontics/Invisalign Y N
Periodontal Disease Y N
Teeth clenching YN
Teeth grinding Y N
Tooth pain Y N
Wisdom teeth extraction Y N
Do you wear removable teeth? y N

Do you take or need antibiotics before dental procedures? y N

Musculoskeletal

Back Pain y N
Fibromyalgia y N
Joint Replacement y N
Joint Pain y N

Neurological

Alzheimer's Disease Y N
Dizziness Y N
Fainting Y N
Memory Loss Y N
Multiple Sclerosis (MS) Y N
Muscle Weakness Y N
Seizures Y N
Stroke Y N
Tingling/Numbness Y N
Trigeminal Neuralgia Y N
Tremor Y N

Psychiatric

ADD/ADHD y N
Anxiety y N
Chemical Dependency y N
Depression y N
Eating disorders y N
Excessive Stress y N
Memory problems y N

Respiratory

Asthma y N
Bronchitis y N
Breathing problems y N
Chest Pressure y N
Congestion y N
Dyspnea(shortncss of breath) y N
Emphysema y N
Orthopnea y N
Pneumonia y N
Pulmonary Embolism y N
Tuberculosis y N

Sleep

Daytime Sleepiness Y N
Morning headaches Y N
Obstructive Sleep Apnea Y N
Do you use a CPAP? Y N
How often?_____
Has anyone told you that you snore? Y N

Social History

Do you smoke? N Y ___packs a day
Do you use smokeless tobacco? Y N
Do you consume alcoholic beverages? _____Drinks per/day/week/month
Do you use recreational drugs? Y N

CONFIDENTIAL

_, MEDICAL HISTORY and CONSE1

List any medications you are taking:

	Medication	Dosage/Freq.	Prescri ber	Reason
1.				
2.				
3.				
4.				
5.				
6.				

List any surgeries or hospitalizations you have had:

Date(yea r)	Surgery	Surgeon	Reason

List and detail any medical condition or history not listed above:

Primary Physician's Name: _____ Physician's phone #: _____

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Family Dental Center, LLC to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Family Dental Center, LLC to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Family Dental Center, LLC choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Family Dental Center, LLC. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT : I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a I 1/2% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Family Dental Center, LLC and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult):

Name of Patient _____ _____ Date _____

Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian _____ _____ Date _____

Signature of Parent/Gua rdian

Notice of Privacy Practices (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regardi ng PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____ Date _____

Signature of Patient

Office Financial Policies

(502) 223-0211

1. **Dental Services:** We offer several payment options cash, check, Discover, American Express, MasterCard, Visa and Care Credit payable at the time of the visit. Our returned check policy of $25.00 will be added onto the check amount for processing bank fees incurred.

_____ (initial)

2. **Insurance Billing:** Patients who wish for our office to bill their insurance company must provide us with the necessary information in order to bill your insurance correctly. We do require you to be responsible for any co-pays or deductibles not met, as well as outstanding balances if your insurance company has not paid within 60 days of the service visit. Insurance billing is provided as a courtesy to our patients. The patient is ultimately responsible for any unpaid balance.

_____ (initial)

3. **Late appointments:** Patients arriving more than Ominutes late to their scheduled appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit.

_____ (initial)

4. **Missed appointments:** We charge;! $50.00 for a missed appointment. We require that you provide 48 working hours notice if you need to cancel or reschedule your appointment.

_____ (initial)

5. **Appointment requiring deposits:** There is a $50.00 fee for any appointment that is $500.00 or larger. The $50.00 will be applied towards services rendered. If patient misses appointment, the $50.00 will be forfeit, unless there is a special circumstance for patient.

_____ (initial)

_____ _____

Patient Signature Date

SIGNATURE RELEASE STATEMENT

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. PROCESS ALL INSURANCE CLAIMS;

2. ENSURE PAYMENT FOR SERVICES PROVIDED

3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS

4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Peters, Dr Scott Jacobs and Dr. Chassity Betzing.

Photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____

Patient Full Name (printed) _____

Parent Signature (if minor) _____

Witness _____

Date Signed _____

Medical Information Release Form HIPAA Release

HIPPA Release Form

Name: _____ Date of Birth:____/____/____

Release of Information

( ) I authorize the release of information including the diagnosis, records, financial information; examination rendered to me and claims information. This information may be released to:

( ) Spouse _____

( ) Child(ren)_____

( ) Other_____

( ) Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ( ) my home ( ) my work ( ) my cell number: ———-,-——

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) _____

The best time to reach me is (day)_____between (time)_____

Signed: _____ Date: ____/___/___

Witness: _____ Date: ____/____/___

Patient Signature _____