Leestown Dental Center
1600 Leestown Rd.
Suite138
Lexington, KY 40511

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

☐ Information In Computer
☐ NP Letter ☐ Thank You Ref. Letter
☐ Scanned

Patient Information

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

Gender: _____ Family 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 Visit:_____ Reason for today's visit: _____

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

MEDICAL HISTORY
☐ Allergies _____
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints (knee, hip or other)
☐ Asthma
☐ Alcohol Abuse
☐ Angioadema (facial swelling after dental tx)
☐ Blood Disease
☐ Blood Transfusion
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Cholesterol
☐ Cold Sores or Fever Blisters
☐ Depression
☐ Diabetes
☐ Diverticulitis
☐ Dizziness / Fainting
☐ Drug Abuse
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Glaucoma
☐ Growths / Tumors
☐ Hay Fever
☐ Head Injuries
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur / MVP
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ HIV
☐ Jaundice
☐ Kidney Disease
☐ Latex Allergy
☐ Liver Disease
☐ Mental Health Issues
☐ MRSA
☐ Migraines
☐ Pacemaker
☐ Pain in Jaw Joints
☐ PTSD
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Snore
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis (TB)
☐ Ulcers
☐ Venereal Disease
☐ Weigh Loss Surgery
☐ Acid Reflux or GERD

DRUG ALLERGIES
☐ Aspirin Allergy
☐ Codeine Allergy
☐ NSAIDS
☐ Penicillin Allergy
☐ Sulfa
☐ Other_____

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

Dental History
☐ Bite/ Chew Nails
☐ Bite guard Therapy
☐ Bleeding Gums
☐ Bleaching Treatment
☐ 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?
_____

Last Dental Cleaning?
_____

- 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: _____

  ☐ List **ALL** Prescribed Medications and over the counter medications:

  _____

  _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain: _____

Referral Information

Whom may we thank for referring you to our practice?

☐Another patient, friend ☐Another patient, relative ☐ Google ☐ Website ☐ Health Fair

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

Name of person or office referring you to our practice: _____

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

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

Insurance Information

Dental Insurance Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ SS #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Other _____

Insurance Plan Name & Address: _____

Dental Insurance Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ SS #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Other _____

Insurance Plan Name & Address: _____

Medical Insurance

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Other _____

Insurance Plan Name and Address: _____

Leestown Dental Center

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:_____ DOB:_____

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:
Leestown Dental Center 1600 Leestown Road, Lexington, KY 40511
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: X_____ 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, _____ have received acknowledgement of this office's Notice of Privacy Practices.

_____ _____
Signature Date
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_____

_____

LEESTOWN
Dental Center

Appointment & Rescheduling Policy

We respect your time by reserving an appointment just for you. That is a reserved time with you and the Doctor or Hygienist. We ask that you respect our time. If you are unable to keep your appointment, please be courteous and call us 24hr prior to change your appointment. We understand emergencies happen sometimes and a short notice is acceptable during those times. However, if you simply **NO SHOW** for your appointment without proper notice, you will be charged a missed appointment fee of **$50 per hour scheduled**. This must be paid prior to us seeing you again.

I understand the importance of keeping my appointments and proper notification for rescheduling.

_____ _____

Patient or Guardian's Signature Date