725 Alexandria Pike, Suite 330
Ft. Thomas, KY 41075
859-781-0221

Date _____

PATIENT INFORMATION

Name _____ Please Circle : Married Single Minor • Male Female

Address_____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____

Telephone Home _____ Work _____ Cell _____

Important: Please provide us with your cell phone number or the number that is best to reach you in case of an emergency. It will save both you and us valuable time.

Has anyone in your family been seen by our office? No Yes Name_____

Email address _____
Herald Family Dentistry has an email system that will help maintain your appointments

Employer or school _____ Grade _____

If patient is a minor, please include parent/guardian's name(s) _____

INSURANCE INFORMATION

Insurance Company _____ Group Number _____

If someone other than yourself carries your insurance please provide us with the following information:
Insurance Carrier's Information:

Name _____ Relationship to Patient _____

Date of Birth _____ Social Security Number _____

Address _____ City_____ State _____ Zip _____

Employer _____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name _____ Phone Number _____

Address _____City _____ State _____ Zip _____

Who may we thank for referring you to our office? _____

AGREEMENT

Insurance:

I understand that the portion of my treatment not covered by insurance is due and payable at each visit. I also understand that my dental insurance is a contract between me and the insurance carrier, and not between my insurance carrier and the dentist, and I am still responsible for dental fees. If my insurance company has not paid their portion within 30 days of being properly billed, I understand that the balance will become due and payable from me.

Service Charge:

If I do not pay the entire New Balance (the "amount due now" on your statement) within 30 days of the date of service, a SERVICE CHARGE will be added to my account for the current monthly billing period. The SERVICE CHARGE will be a periodic rate of 2% per month which is an ANNUAL PERCENTAGE RATE of 24%. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection agency costs and reasonable attorney fees incurred to effect collection on this account.

CONSENT

The undersigned hereby authorizes Doctor to take Xrays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of Dental Services provided in this office for myself or my dependants is mine. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor and authorize the release of any information to my insurance company for consideration of claims to be processed.

_____ _____

Signature of Responsible Party Date

MEDICAL HISTORY

* 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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Your Name:_____ Today's Date:_____

Family Physician Name:_____ Date of last Visit:_____

Have you ever been informed that you need pre-medication prior to dental treatment? _____ if yes describe: _____

Have you had any serious illness or operations? _____ if yes, describe:_____

Have you ever had a blood transfusion?_____ If yes, give approximate dates: _____

Women: ☐ Are you pregnant? ☐ Nursing? ☐ Birth Control Pills?

CHECK NEXT TO ANYTHING THAT APPLIES:

___Anemia
___Arthritis, Rheumatism
___Artificial Heart Valves
___Artificial Joints
___Asthma
___Back Problems
___Blood Disease
___Cancer
___Chemical Dependency
___Chemotherapy
___Circulatory Problems
___ Acid Reflux
___Cortisone Treatments
___Cough, Persistent
___Cough Up Blood
___Diabetes
___Epilepsy
___Fainting
___Glaucoma
___Headaches
___Heart Murmur
___Heart Problems
___Hemophilia
___Hepatitis
___High Blood Pressure
___HIV/AIDS
___Jaw Pain
___Kidney Disease
___Liver Disease
___Mitral Valve Prolapse
___Pacemaker
___Radiation Treatment
___Respiratory Disease
___Rheumatic Fever
___Scarlet Fever
___Shortness of Breath
___Skin Rash
___Stroke
___Swelling Feet/Ankles
___Thyroid Problems
___Tobacco Habit
___Tonsillitis
___Tuberculosis
___Ulcer
___Venereal Disease

Any other conditions not listed: _____

History of Bisphosphonates? (Osteoporosis drug. Ex: Fosamax) YES / NO If yes, please describe:
_____

Allergies:
_____ NONE _____Codeine
_____ Penicillin _____Sulfa
_____ Latex _____Ibuprofen
Other:_____
_____

MEDICATIONS. Please list medications you are currently taking

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_____

Dental History

Chief dental concern/reason for today's visit_____

☐ Current Tobacco user→ what kind_____
How much/day_____ for how long_____

☐ History of Periodontal Disease/ Scaling and Root Planning. If yes, provide date_____

☐ Previous Tobacco user→ When did you quit_____

☐ Family History of gum disease (parents lost teeth at early age or gum disease on your side of family)

☐ Stress (death of spouse, divorce/separation, death in family, injury/illness, retirement, loss of job, etc.)

☐ Bleeding of Gums.

☐ Taking Dilantin, Ca+ Channel Blockers, or Immunosuppressant's for organ transplantation

☐ Gums swollen or tender.

☐ Jaw pain or tenderness.

☐ Loose teeth/ Broken Fillings.

☐Grinding teeth.

☐ Dry Mouth

☐ Orthodontic Treatment? If yes, provide date_____

How often do you Floss? _____

How often do you Brush? _____

- **If you could change anything about your smile, what would you change?**

Explain:
_____
_____

PRESCRIPTION/DRUG POLICY

Prescriptions will not be filled/refilled after normal business hours, on holidays or weekends when the doctor on call does not have your records. This is for your safety and the safety of others. An early refill on your pain medicine will NOT be granted if you take more than the prescribed amount. **In the event of an emergency in which the Dentist cannot be contacted, you are instructed to visit the nearest urgent care facility.**

Prescriptions will not be filled/refilled if you have cancelled your last appointment, did not show up for your last appointment, if you do not follow through with recommended dental treatment in a timely manner, you have been discharged from the practice, or if you were to return only as needed. WE DO NOT PRACTICE PAIN MANAGEMENT.

Prescriptions that have been lost (or discarded) will not be refilled.

Prescriptions that have been stolen will not be refilled.

During the time of your care at this office, it is your responsibility to inform the Dentist of any and all medications you are currently taking as well as any medications that you have been recently prescribed.

It is our legal duty to report to the authorities the name of a patient whom we believe may be taking, selling, or distributing narcotics or other medications illegally.

We reserve the right to terminate the doctor-patient relationship in the event of any breech in this policy by the patient.

I HAVE READ THE ABOVE AND UNDERSTAND THE PRESCRIPTION POLICIES.

_____ _____

Patient Signature Date

HERALD FAMILY DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practices.

I, (Print Name) _____, have received a copy of this offices' Notice of Privacy Practices.

Please Print Patient Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refuse to sign.

_____ Communication barriers prohibited obtaining the acknowledgment.

_____ An emergency situation prevented us from obtaining acknowledgment.

_____ Other. (Please Specify.)

- _____

HERALD FAMILY DENTISTRY

Office Policies

1. **No Show Fee**. There is a $50.00 no show fee for all missed appointments (except in the case of an emergency). Failure to make an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. We require a 48 hour notice for any cancellations.

2. **Timeliness is required**. We will see you on time and get you out on time unless there is a dental emergency. We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.

3. **Insurance**: Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance, it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well being – we are. We will provide you with an estimate of benefits; however, you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will or will not cover.

4. **Payment for services is REQUIRED at the appointment.** We have several financial options available for all of our patients, including **CARE CREDIT and LENDING CLUB** which offers several 0% interest plans.

5. **Upsets**: It is our company policy to ensure the complete satisfaction of all of our patients with the service and care they receive at our office. However, it is possible on occasion that there may be a misunderstanding or miscommunication between you and our office. We will do everything in our power to make things right by you, should an upset occur. Please bring it to our attention in an appropriate and cordial manner at a time that we can give the matter the proper attention it deserves for effective resolution. Please see our office manager to resolve immediately any upsets that you may have with our office or one of my team.

6. **Emergencies**: It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have a dental emergency, we want you to be assured that we will take care of you. In order to do this, we would like to define what a true dental emergency is. Swelling, bleeding, severe pain that keeps you up at night or requires medication, or a restoration in a visible area that falls out are all considered dental emergencies. If you have any of these symptoms, we ask that you call us right away. We will provide you with the next available emergency appointment.

_____ _____

Patient Signature **Date**