Patient Information

Name_____ **M F**
First **MI** **Last**

Address_____ **City**_____ **State**____ **Zip**_____

Social Security #_____ **Date of Birth** _____

Check Appropriate: Minor____ **Single** ____ **Married** ____ **Divorced** ____ **Widowed** ___ **Separated** ___

If over 18 yrs old and on Parent's Insurance: Name of School _____ **Ft**___ **PT**___

Employer_____ **Phone** _____

Whom may we thank for your Refferal? _____

Emergency Contact Name & Phone # _____

Phone Number of Nearest Relative Not Living With You: _____

PARENT or LEGAL GUARDIAN INFORMATION (ONLY if Patient is Under 18 years old)

Name of Legal Guardian_____

Address _____

Social Security # _____ **Date of Birth** _____ **Phone** _____

Is this person a patient in our office? Yes No

Previous Dentist Name & City _____

Last time your say previous dentist _____ **How often do you brush your teeth?** ____ **Floss:**____

Special dental products used _____

Rate your dental anxiety (circle): NONE MILD MODERATE SEVERE
Cause of anxiety (circle): sound of drill/instruments / shots/injections /worry of pain involved/ past experience
What can we do to relieve your anxiety? _____
What would you like to change about your smile?_____
Would you like information about (circle): Whitening / Gum Disease/ Orthodontics / Proper Oral Hygiene / Tooth replacement options (Implants, Partials, Dentures)

I attest that the above information is complete, accurate and factual. Any changes are my responsibility to communicate to the front office staff of Ruth Family Dental in a timely manner.

X_____ **Date** _____
Signature of Patient or Parent/ Guardian

HEALTH HISTORY UPDATE

Patient Name_____ **Phone#**_____ **Cell#**_____ **Work#**_____

Address_____ **Email:**_____

Please List Prescription Medications & Over the Counter Medications (put purpose if you cannot remember name, such as *blood pressure pill or sinus antibiotic*):_____

Allergies (circle): Penicillin Sulfa Codeine Acetaminophen Aspirin Ibuprofen Latex Other list)_____

Have you ever had a reaction to Epinephrine or any dental anesthetic used to get you numb? Yes No_____

Please circle YES if you have or have ever had the following conditions and circle NO if the condition does not apply to you:

AIDS or Hiv Infection	Yes No	Heart Murmur	Yes No	Neurological Disorder_____	Yes No
Anemia	Yes No	Heart Attack	Yes No	Developmental Disorder_____	Yes No
Asthma	Yes No	Bypass	Yes No	Radiation Treatment	Yes No
Arthritis	Yes No	Stent	Yes No	Rheumatic Fever	Yes No
Prolong Bleeding	Yes No	Valve Replacement	Yes No	Sinus Trouble	Yes No
Cancer-type_____When?_____	Yes No	Congenital Heart Defect	Yes No	Seasonal Allergies Mild Moderate	Severe
Oral Cancer When?_____	Yes No	Cardiac Pacemaker	Yes No	Seizures/Fainting	Yes No
Chemo treatment When?_____	Yes No	Other Heart Condition_____		Severe Gag Reflux	Yes No
Premed for Dental Appointment	Yes No	High Blood Pressure	Yes No	Sexually Transmitted Disease	Yes No
Diabetes	Yes No	Low Blood Pressure	Yes No	Strokes	Yes No
Epilepsy/Convulsions	Yes No	Kidney Disease	Yes No	Thyroid Problems	Yes No
Eating Disorder	Yes No	Liver Disease	Yes No	Tuberculosis or Lung Disease	Yes No
Hepatitis Type_____	Yes No	Lung Problems	Yes No	Ulcers/Stomach Troubles	Yes No
Glaucoma	Yes No	Leukemia	Yes No	Joint Replacement	
Infectious/Contagious Disease	Yes No	Mental/ Anxiety Disorder	Yes No	What?_____When?_____	
Headaches	Yes No	Pregnant Due Date_____		What?_____When?_____	

List any other medical problems:_____ **Tobacco Products Used & Frequency:**_____

Describe ANY (not just dental) surgeries you have had in the past 5 years or since your last visit or any you believe are significant:

PRIMARY DENTAL INSURANCE INFORMATION (CONFIDENTIAL)

Name of Policyholder_____ Relationship to Patient_____

Policyholder Social Security #_____ Policyholder Birthdate_____ Employer_____

Dental Insurance Co_____ Group #_____ Policyholder ID_____

Emergency Contact Person:_____ **Emergency Contact Phone Number:**_____

X _____ Date_____
Signature

X _____ Date_____

X _____ Date_____

X _____ Date_____

Ruth Family Dental
7600 Outer Loop
Louisville, Ky 40228

To All Patients:

In order to keep our billing costs and ultimately our prices under control, payments for all dental services is required on the day services are rendered. If you have dental insurance we will do our best to estimate your portion as accurately as possible and we will collect that amount on the day services are rendered unless other payment arrangements have been made prior to that day's appointment. This is only an estimate. YOU ARE RESPONSIBLE FOR ALL CHARGES NOT PAID BY YOUR INSURANC CARRIER!

Our office will continue to file insurance claims as a courtesy to our patients at no cost. However, we cannot guarantee that your insurance company will pay or what amount they will pay on any claim. The contract with your insurance company is between you and your insurance company. We will collect an estimated amount. In addition some insurance companies are very slow in paying claims. Any amount not paid within 60 days of service is due and payable by the patient.

If you are notified your claim has not been paid we urge you to notify your employee benefits manager or the Kentucky Insurance Commissioner at the following address.

Kentucky Department of Insurance
P.O. Box 517
Frankfort, Ky 40602-0517

In the event of nonpayment which results in this account or a dependent's account being turned over to an attorney or collection agency. I agree to pay all legal costs, disbursements, and collection agency fees that Ruth Family Dental may incur.

_____ _____

Signature of Responsible Party or Patient **Witness**

_____

Date

HIPAA OMNIBUS RULE
PATIENT ACKNOLWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____

Please **print** name of Patient **Signature** of Patient or Parent/Guardian

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO ADDRESS WHEN SUMMONED FROM THE RECEPTION AREA:
FIRST NAME ONLY _____ PROPER SURNAME_____ OTHER_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents, and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENT, TREATMENT & BILLING INFORMATION** VIA:

____Cell Phone Confirmation
____Home Phone Confirmation
____Work Phone Confirmation
____ Text Message to my Cell Phone
____Email Confirmation
____**Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

____Cell Phone Notification
____Home Phone Notification
____Work Phone Notification
____Text Message to my Cell Phone
____Email Notification
____**Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS, OR NEW HEALTH INFO** on behalf of this Healthcare Facility via:

____ Phone Message
____ Text Message
____ Email
____ **ANY OF THE ABOVE**
____**NONE OF THE ABOVE (opt out)**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to Obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer