Patient Registration

First Name: _____ **MI:** ____ **Last Name:** _____

Preferred Name: _____

Date of Birth: _____ **Gender:** _____ **SSN:** _____

Responsible Party: Self / Other_____

Patient Address:

Address 1: _____

Address 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ Home/ Work/ Mobile

Phone Number: _____ Home/ Work/ Mobile

Phone Number: _____ Other **Email:** _____

Preferred Hygienist: _____

Preferred Pharmacy: _____

Patient Insurance

Primary Insurance Information

Carrier Name: _____ **Effective Date:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Policy Holder: Self / Other **Plan Name:** _____

Policy Holder ID: _____ **Policy Holder Date of Birth:** _____

Relationship to Policy Holder: _____

Plan #2 Insurance Information

Carrier Name: _____ **Effective Date:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Policy Holder: Self / Other **Plan Name:** _____

Policy Holder ID: _____ **Policy Holder Date of Birth:** _____

Relationship to Policy Holder: _____

FRENCH - CLEVIDENCE
FAMILY DENTISTRY PSC
(270) 389-0812
P.O. BOX 553 MORGANFIELD, KY 42437

Authorization for Release of Personal Information

Patient Name _____

Patient Address _____

Patient Phone Number _____

I give my consent for French and Clevidence Family Dentistry DMD PSC to speak with those parties listed below regarding my health, dental treatment, and all finances.

I authorize release of my personal information to the following:

Name #1:_____

Name #2:_____

Name #3: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose to not sign this authorization. If you choose to not list any person, we will not be able to speak with them if they call on your behalf.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the office at the address listed above.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION, DENTAL TREATMENT, AND FINANCES AS DESCRIBED IN THIS FORM.

Signature _____ Date _____

05/17/2024

Medical History Form

Patient Name: _____ Emergency Contact _____

Date of Birth: _____ Emergency Contact Phone _____

Sex: _____ Emergency Contact Relationship _____

Do you have any of the following diseases or problems

Active Tuberculosis ..... Yes No

Persistent cough greater than a 3 week duration ..... Yes No

Cough that produces blood ..... Yes No

Been exposed to anyone with tuberculosis ..... Yes No

Medical History

Are you now under the care of a physician? ..... Yes No

Physician Name _____

Phone (including area code) _____

Address/City/State/Zip _____

Are you in good health? ..... Yes No

Has there been any change in your general health within the past year? ..... Yes No

If yes, what condition is being treated? _____

Date of last physical exam _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ..... Yes No

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ..... Yes No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

_____

Do you wear contact lenses? ..... Yes No

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? ..... Yes No

Date _____

If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No

Date Treatment began _____

Do you use controlled substances (drugs)? ..... Yes No

Do you use tobacco (smoking, snuff, chew, bidis)? ..... Yes No

If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____

Do you drink alcoholic beverages? ..... Yes No

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY. Are you:

Pregnant ..... Yes No

Number of weeks _____

Taking birth control pills or hormonal replacement? ..... Yes No

Nursing? ..... Yes No

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics ..... Yes No

Penicillin ..... Yes No

Aspirin ..... Yes No

Barbiturates, sedatives, or sleeping pills ..... Yes No

Sulfa drugs ..... Yes No

Codeine or other narcotics ..... Yes No

Metals ..... Yes No

Latex (rubber) ..... Yes No

Iodine ..... Yes No

Hay fever/seasonal ..... Yes No

Animals ..... Yes No

Food ..... Yes No

Other ..... Yes No

If Other, please specify: _____

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve ..... Yes No

Previous infective endocarditis ..... Yes No

Damaged valves in transplanted heart ..... Yes No

Congenital heart disease (CHD) ..... Yes No

Unrepaired, cyanotic CHD ..... Yes No

Repaired (completely) in the last 6 months ..... Yes No

Repaired CHD with residual defects ..... Yes No

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease ..... Yes No

Angina ..... Yes No

Arteriosclerosis ..... Yes No

Congestive heart failure ..... Yes No

Damaged heart valves ..... Yes No

Heart attack ..... Yes No

Heart murmur ..... Yes No

Low blood pressure ..... Yes No

High blood pressure ..... Yes No

Other congenital heart defects ..... Yes No

Mitral valve prolapse ..... Yes No

Pacemaker ..... Yes No

Rheumatic fever ..... Yes No

Rheumatic heart disease ..... Yes No

Abnormal bleeding ..... Yes No

Anemia ..... Yes No

Blood transfusion ..... Yes No

If yes, date _____

Hemophilia ..... Yes No

AIDS or HIV ..... Yes No

Arthritis ..... Yes No

Autoimmune disease ..... Yes No

Rheumatoid arthritis ..... Yes No

Systemic lupus erythematosus ..... Yes No

Asthma ..... Yes No

Bronchitis ..... Yes No

Emphysema ..... Yes No

Sinus trouble ..... Yes No

Tuberculosis ..... Yes No

Cancer/Chemotherapy/Radiation Treatment ..... Yes No

Chest pain upon exertion ..... Yes No

Chronic pain ..... Yes No

Diabetes Type I or II ..... Yes No

Eating disorder ..... Yes No

Malnutrition ..... Yes No

Gastrointestinal disease ..... Yes No

G.E. Reflux/persistent heartburn ..... Yes No

Thyroid problems ..... Yes No

Stroke ..... Yes No

Glaucoma ..... Yes No

Hepatitis, jaundice or liver disease ..... Yes No

Epilepsy ..... Yes No

Fainting spells or seizures ..... Yes No

Neurological disorders ..... Yes No

If yes, please specify _____

Sleep disorder ..... Yes No

Mental health disorders ..... Yes No

Specify _____

Recurrent infections ..... Yes No

Type of infection _____

Kidney problems ..... Yes No

Night sweats ..... Yes No

Osteoporosis ..... Yes No

Persistent swollen glands in neck ..... Yes No

Severe headaches/migraines ..... Yes No

Severe or rapid weight loss ..... Yes No

Sexually transmitted disease ..... Yes No

Excessive urination ..... Yes No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ..... Yes No

Name of physician or dentist making recommendation (include phone number) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No

Please explain _____

Date _____ Signature _____

Dr. French-Clevidence
Family Dentistry DMD PSC
P. O. Box 553
Morganfield, KY 42437
(270) 389-0812

PRIVACY CONSENT

This form is required by the new patient privacy regulations recently issued by the United States Department of Health and Human Services. Prior to commencing your dental treatment, you must review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent Form, a copy of which was given to you with this Consent Form.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

_____
Patient's Signature (Parent/Legal Guardian)

_____
Print Patient Name

_____
Date

FINANCIAL RESPONSIBILITY

Many patients have a commonly held misconception that dental benefit policies, either purchased by their employers or an individually purchased plan, will pay for all their treatment. This is incorrect and untrue.

As a patient in this office, you will receive a treatment plan that is specific to the problems that are noted during your initial examination. Your doctor will carefully review her findings with you and explain to you the treatment options, if any, that are available to you. In return, your financial responsibility for this treatment will be to the doctor's office. We will be glad to assist you in obtaining reimbursement for part of these benefits from your insurance provider.

Please understand that insurance payment does not guarantee payment even though you may feel that you have the coverage. Financial responsibility for services you receive at the office is yours alone. It is your responsibility to provide the correct dental policy information as the office will not be responsible for any incorrect information.

Also note if you need to change or cancel your appointment, please provide a 24 business hour notice. If we do not have advance notice, there will be a missed appointment charge applied to your account of $75.

Thank you for your confidence in our office. We look forward to providing you with competent care and courteous service.

Sincerely,

Dr. Brittany French-Clevidence and Staff

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO DR. BRITTANY FRENCH-CLEVIDENCE FOR ALL CARE AND SERVICES PROVIDED TO ME.

Patient Name:_____ Date:_____

Responsible Party Signature:_____

French & Clevidence Family Dentistry DMD PSC

825 US HWY 60 E
Morganfield KY 42437
270-389-0812

You agree to reimburse us the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33.3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fee incurred by the collection agency. This contract shall cover all treatment and services until revoked by either party in writing.

Print Name: _____

Signature: _____

Date: _____