PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Test

Dental Insurance

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes	Cortisone Medicine ◯ Yes	Hemophilia ◯ Yes	Radiation Treatments ◯ Yes
Alzheimer's Disease ◯ Yes	Diabetes ◯ Yes	Hepatitis A ◯ Yes	Recent Weight Loss ◯ Yes
Anaphylaxis ◯ Yes	Drug Addiction ◯ Yes	Hepatitis B or C ◯ Yes	Renal Dialysis ◯ Yes
Anemia ◯ Yes	Easily Winded ◯ Yes	Herpes ◯ Yes	Rheumatic Fever ◯ Yes
Angina ◯ Yes	Emphysema ◯ Yes	High Blood Pressure ◯ Yes	Rheumatism ◯ Yes
Arthritis/Gout ◯ Yes	Epilepsy or Seizures ◯ Yes	High Cholesterol ◯ Yes	Scarlet Fever ◯ Yes
Artificial Heart Valve ◯ Yes	Excessive Bleeding ◯ Yes	Hives or Rash ◯ Yes	Shingles ◯ Yes
Artificial Joint ◯ Yes	Excessive Thirst ◯ Yes	Hypoglycemia ◯ Yes	Sickle Cell Disease ◯ Yes
Asthma ◯ Yes	Fainting Spells/Dizziness ◯ Yes	Irregular Heartbeat ◯ Yes	Sinus Trouble ◯ Yes
Blood Disease ◯ Yes	Frequent Cough ◯ Yes	Kidney Problems ◯ Yes	Spina Bifida ◯ Yes
Blood Transfusion ◯ Yes	Frequent Diarrhea ◯ Yes	Leukemia ◯ Yes	Stomach/Intestinal Disease ◯ Yes
Breathing Problem ◯ Yes	Frequent Headaches ◯ Yes	Liver Disease ◯ Yes	Stroke ◯ Yes
Bruise Easily ◯ Yes	Genital Herpes ◯ Yes	Low Blood Pressure ◯ Yes	Swelling of Limbs ◯ Yes
Cancer ◯ Yes	Glaucoma ◯ Yes	Lung Disease ◯ Yes	Thyroid Disease ◯ Yes
Chemotherapy ◯ Yes	Hay Fever ◯ Yes	Mitral Valve Prolapse ◯ Yes	Tonsillitis ◯ Yes
Chest Pains ◯ Yes	Heart Attack/Failure ◯ Yes	Osteoporosis ◯ Yes	Tuberculosis ◯ Yes
Cold Sores/Fever Blisters ◯ Yes	Heart Murmur ◯ Yes	Pain in Jaw Joints ◯ Yes	Tumors or Growths ◯ Yes
Congenital Heart Disorder ◯ Yes	Heart Pacemaker ◯ Yes	Parathyroid Disease ◯ Yes	Ulcers ◯ Yes
Convulsions ◯ Yes	Heart Trouble/Disease ◯ Yes	Psychiatric Care ◯ Yes	Venereal Disease ◯ Yes
			Yellow Jaundice ◯ Yes

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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 _____

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be canceled at least 24 hours in advance.

Our Doctors and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen. **If you miss your appointment, or cancel with less than 24 hours notice, you will be charged $25.**

This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Dental Insurance Policy

We will be happy to file your dental insurance, however, in order to file with in and out of network insurance companies, you are responsible for providing the correct dental insurance information. We will not be responsible for any incorrect information given to us and any error in billing due to incorrect dental insurance information. You will be financially obligated to any unpaid balances.

By signing below, you acknowledge that you have read and understand the cancellation policy and insurance policy as described above.

Thank you for being a valued patient and for your understanding!

Printed Name _____ Signature _____

Date _____

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 _____

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

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 fees incurred by the collection agency. This contract shall cover all treatment and services until revoked by either party in writing.

Print Name: _____

Signature: _____

Date: _____