PROSPECT

DENTAL CARE

SARA S. CUMMINS, DMD

Thank you for choosing Prospect Dental Care

Patient Name: _____

Today's Date: _____

Birth Date: _____

SSN: _____

Phone Number: _____

Address: _____

_____

How would you prefer that we contact you to confirm your appointments?

- Phone call, the best number to reach me is:_____
- Email:_____
- Other:_____

Whom may we thank for referring you to our practice?_____

What is your occupation?_____

What can we do to ensure you have a great dental visit today?_____

Dental Insurance Information:

If you have dental insurance, please allow us to make a copy of your insurance card, or list the following information about your dental insurance policy holder (if not yourself) and plan.

Insurance Name: _____

Employer: _____

Phone number of insurance: _____

SSN and birthdate of Subscriber: _____

Group and ID#: _____

6007 TIMBER RIDGE DR. PROSPECT, KY 40059 • **PHONE** 502.228.4700 **FAX** 502.228.4797

PROSPECTDENTALCARE.COM

Please list all medications you are currently taking:

_____

_____

_____

Have you ever been hospitalized? Yes No

If yes, please describe when and why:

_____

Women only:

Is there a possibility you might be pregnant? Yes No

Are you nursing? Yes No

Do you take birth control pills? Yes No

Dental History

Are you happy with the appearance of your smile? Yes No

What do you like or dislike about it? _____

Is there anything you'd like to change regarding your teeth? Yes No

If so, please elaborate: _____

How important is your overall oral health to you? _____

Approximately when was your last dental checkup? _____

Do you make regular (non-emergency) visits to the dentist? Yes No

Are you having dental pain today? Yes No

Are your teeth painful to biting or chewing? Yes No

Do your teeth feel loose? Yes No

Do your gums bleed when you brush your teeth? Yes No

Have you ever had a negative experience related to dental treatment? Yes No

Do you gag easily during dental treatment? Yes No

Do you ever have pain, clicking or popping when you open and close your mouth? Yes No

Do you grind or frequently clench your teeth? Yes No

Does your mouth frequently feel dry? Yes No

Have you ever worn braces? Yes No

Do you wear a removable denture? Yes No

Emergency Contact & Phone Number: _____

Relationship to patient: _____

To the best of my knowledge, the stated responses are correct and true. If there are any changes in my health history, I will inform the dentist or hygienist at the next appointment.

Signature _____ Date _____

Relationship to patient (if parent or guardian) _____

Medical Health History

Patient's Name: _____
Physician's Name: _____

Are you currently under the care of a physician? Yes or No
Phone Number: _____

Please indicate any condition that you have had in the past or have now by checking the applicable conditions & filling in the blank spaces when indicated.

CARDIOVASCULAR

- o Congestive heart failure
- o Heart disease or attack
- o Angina or chest pains
- o High blood pressure
- o Heart murmur or click
- o Mitral valve prolapse
- o Rheumatic fever
- o Congenital heart defect or lesion
- o Heart surgery or transplant
- o Artificial heart valve
- o Irregular heartbeat (arrhythmia)
- o Pacemaker or defibrillator
- o Other heart problem:_____

HEMATOLOGIC

- o Do you take any blood thinners?
- o Blood transfusion
- o Anemia
- o Sickle cell (anemia) disease
- o Tendency to bleed longer than normal
- o Hemophilia
- o Leukemia

NEURAL

- o Stroke or transient ischemic attack
- o Vision problems
- o Glaucoma or cataract
- o Earaches, ringing in ears
- o Hearing loss
- o Severe headaches, migraines
- o Fainting or dizzy spells
- o Epilepsy, seizures or convulsions
- o Nervous disorders
- o Depression
- o Psychiatric treatment

ALLERGIES

- o Aspirin
- o Codeine
- o Any other pain medications
  If so, please list: _____
- o Sulfa drugs
- o Penicillin
- o Any other antibiotics
  If so, please list: _____
- o Have you ever had an adverse reaction to local anesthesia? _____

GASTROINTESTINAL

- o Stomach or intestinal ulcers
- o Gastritis or esophageal reflux
- o Colitis
- o Hepatitis or jaundice
- o Cirrhosis
- o Other liver problem: _____

GENITO-URINARY

- o Kidney or bladder problems
- o Dialysis
- o Sexually transmitted disease: _____

RESPIRATORY

- o Hay fever
- o Sinus trouble
- o Asthma
- o Persistent cough
- o Bronchitis
- o Emphysema / COPD
- o Tuberculosis
- o Breathing difficulties

ENDOCRINE

- o Diabetes
- o Thyroid disease

DERMAL/ORAL/MUSCULOSKELETAL

- o Allergy to latex
- o Skin rash or hives
- o Arthritis, rheumatism or gout
- o Artificial joint
  If so, what was the date of your most recent joint replacement? _____
- o Fever blisters
- o Mouth ulcers or canker sores

OTHER CONDITIONS

- o Enlarged lymph node or gland
- o Tobacco use
- o Alcohol addiction
- o Drug addiction
- o Tumor or cancer
- o Radiation treatment
- o Chemotherapy
- o HIV or AIDS
- o Any other condition not listed on this form:
  _____
  _____

Consent for Treatment and Promise of Payment

I hereby consent to the performance of a course of dental procedures, deemed necessary and desirable for any condition found on examination, or any dental treatment or procedures which may later become apparent during treatment. This consent shall extend to all treatments, services, medications and operations upon the teeth and jaws as may be necessary to correct oral deficiency, abnormality and/or infection. I consent to the administration of anesthetic agents for my dental treatment. I acknowledge that no guarantee or assurance is made as to the results that may be obtained.

I understand that services and cost may change once treatment commences. I acknowledge that I am fully responsible for all fees incurred, and any applicable insurance is not promise of payment. I understand that I am responsible for any problems, delays, or denials for payment with my insurance company. If my account becomes delinquent it will go to a collections lawyer, and I am fully responsible for all filing, collections, and delinquent account charges.

Signature _____ Date _____

Relationship to patient (if parent or guardian) _____

Consent for Use and Disclosure of Health Information
Health Insurance Portability Accountability Act (HIPAA)

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 staff member can provide you with a copy of this Consent, we encourage you to read.

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 Dr. Sara Cummins.

Patient Giving Consent

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 _____ Date _____

Relationship to patient (if parent or guardian) _____

Patient Revoking 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 _____

Relationship to patient (if parent or guardian) _____

Notice of Privacy Practices

I acknowledge that I have been notified that our NOTICE OF PRACTICE POLICIES can be obtained via our office. This document is printable via the website for your website for your records.

HIPAA website: http://www.hhs.gov/ocr/hipaa/finalreg.html (You may refuse to sign this acknowledgement)

Signature _____ Date _____

Relationship to patient (if parent or guardian) _____

CONSENT FOR PHOTO/IMAGE USE

I, the undersigned, hereby authorize the office of Dr. Sara Cummins to use the following images to be placed in a book of case samples, or for marketing or advertising purposes:

_____ *Before and after pictures of my teeth*

_____ *Before and after pictures of my full face*

_____ *Before and after pictures of the teeth and/or full face of my minor child*

_____ *Refusal of photos/images*

By signing this authorization I waive any claims of breach of privacy pertaining to the release of any photographic or digital images as checked above. I acknowledge that I have received a copy of the private policies of this office.

_____ _____

Signature of Patient or Parent *Date*

_____ _____

Witness Signature (member of staff) *Date*

Written Financial Policy

Thank you for choosing Prospect Dental Care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

-Visa, MasterCard, American Express, Discover Card or Cash, Check

-NO INTEREST[1] Payment Plans[2] from Care Credit

Please note:

Prospect Dental Care requires full payment on the day your service is provided. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. We will inform you if this occurs and you will be given the option of continuing or changing treatment. If you choose to discontinue care before treatment is complete, any available refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. **However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.**

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

[1] If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
[2] Subject to credit approval