Patient Information

First Name:_____ MI:____ Last Name:_____ Sex: ☐ Male ☐ Female

Preferred Name: _____ Date Of Birth: _____ Social Security #:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Primary Contact Number: ☐ Home ☐ Work ☐ Cell Best Time To Call:_____

Email:_____ Fax:_____ Driver's License #:_____

Employer:_____ Occupation:_____

Spouse's Name:_____ Spouse's Employer:_____

Whom may we thank for referring you?:_____

If the patient is a child:

School:_____ School Phone:_____ Grade:_____

Person Financially Responsible for Account (if the patient is an adult, please skip to payment method)

Full Name:_____ Relationship to Patient:_____

Social Security #:_____ Phone:_____ Driver's License #:_____

Date Of Birth:_____ Employer:_____

Payment method:

Preferred payment method: Cash Credit Card Check

Card #:_____ Name on Card:_____ Exp Date:_____

Emergency Contact(s)

Full Name:_____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Full Name:_____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Dental Insurance

Primary Carrier

Insurance co. name:_____ Insurance co. phone:_____

Address:_____City:_____ State:_____Zip:_____

Group no. (Plan or Policy no.)_____ Insurance I.D. no. :_____

Insured's name:_____ Relationship to Patient:_____

Date of Birth:_____Insured's social security no. :_____ Employer Name:_____

Secondary Carrier

Insurance co. name:_____ Insurance co. phone:_____

Address:_____City:_____ State:_____Zip:_____

Group no. (Plan or Policy no.)_____ Insurance I.D. no. :_____

Insured's name:_____ Relationship to Patient:_____

Date of Birth:_____Insured's social security no. :_____ Employer Name:_____

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

I agree to reimburse Pennyrile Family Dentistry 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 cost 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 medical/dental treatment and services until revoked by either party in writing.

Patient Signature:_____ Date:_____

Eaglesoft Medical History(Copy2)(Copy)

Patient Name: Birth Date: Date Created:

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
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsilitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

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

Comments:

I agree to reimburse Pennyrile Family Dentistry 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 cost 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 medical/dental treatment and services until revoked by either party in writing.

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

X

Date:

Pennyrile Family Dentistry Office Policies

Payment will be expected at the time of service for all non-contracted fees and co pays.

Insurance Contracts: If we are in contract with your insurance carrier, we will accept assignment on all covered services and bill your carrier for you. You are responsible for the co pay, coinsurance, deductible, and for all non-covered services.

Insurance plans represent a contract between you and the insurance company. These contracts are not between the doctor and the insurance company. We will do our best to help you obtain benefit information, but we cannot be responsible if your insurance carrier does not pay. Further, if a member of our staff advises you that you are fully covered or implies that you will owe nothing, it is your responsibility to verify with your insurance company. It is also your responsibility to make certain your insurance carrier makes prompt payment, and to handle any disputes that may arise.

Third party financing may be available through CareCredit for patients requiring extensive treatment. This type of financing must be approved in advance. Interest free financing is available for treatment plans over $300. Extended plans are also offered for 24, 36, or 48 months with a fixed payment 9.9% APR. Please refer to CareCredit or ask a staff member for further details.

For appointments lasting longer than an **hour and a half**, we ask that you put **10%** down.

Missed Appointments: Cancellations must be made within **24 hours** of appointment. Failure to confirm an appointment by text or phone call may result in cancellation of said appointment. If an appointment is missed, we reserve the right to apply a $25/hour missed appointment fee that will be billed directly to you.

Tardiness: Please respect our time as we do yours. In the event that you are running late for an appointment, we may have to reschedule due to time constraints.

Cell Phones: We request all cellular phones be turned off or placed on silent mode while in the building.

We reserve the right to dismiss any patient from our practice for inappropriate behavior while in our office.

Thank you for trusting us with your dental health care. If at any time you have questions regarding any treatment, fees, or services please discuss them with us promptly. We will make every effort to avoid misunderstanding, rectify an injustice, and preserve friendship.

I acknowledge that I have read the above information.

Signature of Patient or Guardian: _____

Printed Name: _____

Date: _____

Pennyrile Family Dentistry, LLC

Dr. Joseph Falco and Dr. Ryan Vonnahme

Patient's Guide for Controlled Substances

Due to a new state law, your physician must take additional steps before prescribing certain controlled substances.

Your Dentist is required to obtain a **KASPER** (Kentucky All Schedule Electronic Reporting System) report on you prior to prescribing any controlled substance. KASPER is an electronic monitoring system that provides information on controlled substances you have been prescribed and had filled in Kentucky or other participating state pharmacies. Other requirements of the law include taking a medical history, performing a physical exam, and obtaining written consent.

Controlled substances can be used effectively to treat acute pain to allow you to recover from surgery, injury or other condition. This type of treatment rarely causes addiction. Medication should be discontinued when the condition is improved.

To reduce your chance of developing an addiction, you should take medications exactly as prescribed by your doctor. Also, be sure to let your doctor know of all other medications you are taking, including over the counter medications or herbal supplements.

You should also let your doctor know if you:

- Experience an increase in the amount of medication you need
- Are unable to limit or stop the medication use
- Experience withdrawal symptoms when stopping the medication (such as sweating, anxiety, nausea and vomiting, etc.) as these can be a sign of addiction.

Any unused medication may be taken to your local law enforcement office for disposal. You may also, in accordance with the FDA recommendations for disposal, remove the mediation from its original container and mix with an undesirable substance, such as used coffee grounds or kitty litter, then place in the household trash. Medications should not be flushed down the drains. When in doubt, you should speak to your pharmacist.

Consent for Treatment with Controlled Substances

I understand there are benefits and risks associated with taking controlled substances, including the risk of developing drug tolerance or dependence. I am aware of the risks, benefits, and alternatives. I consent to treatment with a controlled substance if my doctor deems it appropriate.

Also, by signing this consent, I am verifying that I am not receiving pain medication by any other provider that my doctor is not aware of. If it is determined that I am receiving pain medication from another provider, I understand there will be no future prescriptions written.

This consent is valid one calendar year from the date signed.

Patient Signature or Person Authorized to Sign for the Patient: _____

Printed Name: _____

Date: _____ **Time:** _____

Patient SSN: _____ **DOB:** _____

Patient Address: _____

Pharmacy Name and Number: _____

Doctor: _____ **Witness:** _____

SPRINT PRINT FORM #H10532

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Pennyrile Family Dentistry
623 Millbrooke Dr.
Hopkinsville, KY 42240
(270) 885-4822

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: