PENNYRILE FAMILY DENTISTRY

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

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 Section 3

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.: _____

How did you hear about our office?

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: _____.00 Rem. Deduct: _____.00

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: .00 Rem. Deduct: _____.00

Pennyrile Family Dentistry

Medical History

PATIENT NAME _____ **BIRTH DATE** _____

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 ◯ 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 Problem ◯ 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	Tonsillitis ◯ 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, please explain: _____

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 health. It is my responsibility to inform the dental office of any changes in medical status

SIGNATURE OR PATIENT, PARENT, OR GUARDIAN _____ **DATE** _____

Pennyrile Family Dentistry, LLC

Dr. Joseph Falco, Dr. Ryan Vonnahme and Dr. Zachary Garnett

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:** _____

DENTAL TREATMENT CONSENT FORM

Please read and initial the items below
And read and sign the section at the bottom of form.

Patient Name_____

1. **Diagnostic and preventive** (Initials _____)
   X-rays, Cleaning, Scaling

2. **Drugs and Medications** (Initials _____)
   I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. **Nitrous Oxide** (Initials _____)
   I understand that Nitrous oxide provides relaxation to make it more comfortable for me to receive the necessary dental care with less anxiety. I will be awake, fully conscious, aware of my surroundings, and able to respond rationally. I have informed the doctor of my complete medical history including any recent surgeries or changes in my medical history.

4. **Local Anesthetic** (Initials_____)
   I understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, numbness, tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes in my medical history.

6. **Removal of Teeth** (Initials _____)
   Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.). I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

7. **Crowns and Bridges** (Initials _____)
   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit, size and color) will be before cementation.

8. **Dentures, Complete or Partial** (Initials _____)
   I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fees.

9. **Endodontic Treatment (Root Canal)** (Initials_____)
   I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal posts are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally surgical procedures may be necessary following root canal treatment (apicoectomy).

10. We invite you to discuss with us any questions regarding our service. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment by which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of patient or legal guardian _____ Date _____

Pennyrile Family Dentistry

Dr. Joseph N. Falco, IV
Dr. Ryan Vonnahme
Dr. Zachary Garnett
205 Burley Ave.
Hopkinsville, KY 42240

Missed appointments. Our policy is to charge for missed appointments not canceled within 24 hours. This charge of $25 will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our missed appointments policy. Please let us know if you have any questions or concerns.

I have read and understand the missed appointment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **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 benefits, but we cannot be responsible if your 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 contact your insurance company for verification. Therefore, it is your responsibility to make certain your 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 the CareCredit brochure 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 to reserve the doctor's time.

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 a misunderstanding, to rectify an injustice, and preserve a friendship.

Missed Appointments: Cancellations must be called in within **24 hours** of appointment. Regretfully, repeated failure to make your appointments may result in your dismissal as a patient from Pennyrile Family Dentistry.

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

Cellular Phones/pagers: We request all cellular phones and pagers be turned off or put on silent mode during your appointment.

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

I acknowledge that I am responsible to pay all charges for treatment administration by Pennyrile Family Dentistry as outlined above.

Responsible Party Signature: _____

Printed Name: _____

Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Pennyrile Family Dentistry
205 Burley Ave.
Hopkinsville, KY 42240
(270) 632-6404

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: