Carnes Family Dental

Carnes Family Dental
520 N. Miles St
Elizabethtown, KY, 42701
2707657408
www.dentistinelizabethtownky.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date: / /	Patient #:

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Marital Status:	Social Security #: - -	Driver's Licence State & #:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone: - -	Occupation:

Employer's Address:	City:	State:	ZIP Code:

Student Status:	School Name (if a full-time student):	Grade:

Best places and times to contact you:	Send appointment reminders via: ❑ Text Message ❑ Email ❑ Mail

Please tell us where you heard about us (check all that apply):

❑ Friend or Relative (name): ❑ Newspaper Ad ❑ Radio Ad ❑ TV Ad
❑ Ad in Mail ❑ Saw our Office ❑ Insurance Company ❑ Our Website
❑ Search Engine (Google, etc.) ❑ Other Website:
❑ Other:

Was our website a factor in your decision to visit our practice? ❍ Yes ❍ No

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone: - -	Spouse/Parent Cell Phone: - -

Other family members treated by us:	Additional Comments:

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Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Emergency_Contact Address:	City:	State:	ZIP Code:

Person Responsible for Account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Carnes Family Dental to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Carnes Family Dental. I permit a copy of this authorization to be used in place of the original. I give Carnes Family Dental, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):
	/ /

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Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Payment

Does the person responsible for the account already have an account with this office? ❍ Yes ❍ No

Payment Method

Notice: Payment is due at the time of service unless alternative arrangements have been made in advance. Please choose a method of payment below.

Payment in Full

❍ Cash

❍ Check

❍ Credit Card

Type:	Credit Card Number:	Expiration: / 2016	Card Verification Code: VISA/MC/Discover: 3-digit code printed on back AmEx: 4-digit code printed on front

Your credit card information is kept on file for outstanding account balances.

Payment Plans

Start treatment immediately and pay over time with low monthly payments.

❍ CareCredit

No-Interest Payment Plans

- Pay for treatment over 6 or 12 months with NO interest.
- As long as you pay the low minimum monthly payment each month when due, and the balance in full by the end of the promotional 6- or 12-month term, no interest will be charged on your purchase.

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Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

Personal checks that are returned due to "insufficient funds" are subject to a $25.00 service fee.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

Patient Name:

I hereby authorize payment directly to Carnes Family Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Carnes Family Dental to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Dental History

Previous Dentist

Dentist Name:	Phone: - -

Last Dental Visit

Last Dental Visit (m/y): /	What were you treated for?	Treatment complete? ❍Yes ❍No

What was done at your last dental visit?	Last X-Rays: /	Last Full-Mouth X-Rays: /	Last Cleaning: /

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Dental Hygiene

How often do you visit a dentist?	Do you brush your teeth? If yes, how often?	Do you floss? If yes, how often?
Regularly	Yes After every meal	Yes After every meal

Please list other dental hygiene aids (Interplak, toothpicks, etc.) that you use:	Are you interested in regular hygiene cleanings?
	Yes

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:
Yes

What is the main reason for your visit today?
❑ Tooth Pain ❑ Check-up ❑ Cleaning ❑ Whitening ❑ Cosmetic Dentistry
❑ Sedation Dentistry ❑ Restorative Dentistry ❑ Other:

What would you like to learn more about?
❑ Whitening ❑ Cosmetic Dentistry ❑ Implants ❑ Bridges ❑ Veneers ❑ Dentures
❑ Laser Treatment ❑ Dermal Filler ❑ Other:

Dental Concerns

Check all that apply.

Teeth

❑ Broken or chipped	❑ Loose/missing filling	❑ Missing teeth	❑ Sensitive to sweets
❑ Crooked	❑ Loose teeth	❑ Mouth sores	❑ Blisters on lips/mouth
❑ Decay	❑ Tooth pain	❑ Sensitive to cold	❑ Orthodontic treatment
❑ Difficulty chewing	❑ Food trap areas	❑ Sensitive to heat	❑ Bad taste in mouth
❑ Discolored	❑ Grinding or clenching	❑ Sensitive when biting	

Gums

❑ Bad breath	❑ Abscessed	❑ Sore	❑ Receding
❑ Red (discolored)	❑ Bleeding	❑ Swollen	❑ Periodontal treatment

Facial/Jaw Pain

❑ Frequent headaches	❑ Pain in temples	❑ Jaw injury	❑ Pain around ear
❑ Avoid certain foods	❑ Jaw locks open/closed	❑ Head injury	
❑ Popping/clicking	❑ Pain in jaw	❑ Neck injury	

Other Concerns

❑ Smoking/dipping	❑ Orthodontic treatment	❑ Snoring
❑ Biting cheeks or lip	❑ Burning tongue	❑ Teeth straightening
❑ Popping/clicking	❑ Tooth replacement	❑ Retainer
❑ TMJ	❑ Fractured tooth syndrome	❑ Dry mouth
❑ Tooth-colored fillings	❑ CPAP	❑ Wisdom teeth extraction
❑ Wisdom teeth	❑ Implants - Tooth #:	❑ Cosmetics
❑ Nail-biting	❑ Jaw locks open/closed	❑ Smile makeover
❑ Sleep apnea	❑ Stain	❑ Dental phobias
❑ Limited orthodontics	❑ Chew on one side	

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Medical History

How is your general health? ❍Good ❍Fair ❍Poor

Are you currently under medical treatment? If yes, what for?

Yes

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Yes

Physician's Name:	Phone: - -	Last Visit: /

Address:	City:	State:	ZIP Code:

Do we have permission to contact your doctor regarding your care? ❍Yes ❍No

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Have you ever had:

Check all that apply.

- ❑ Arthritis
- ❑ Arteriosclerosis
- ❑ Birth defects
- ❑ Cancer
- ❑ Emotional problems
- ❑ Head or face injury
- ❑ Heart murmur/trouble
- ❑ History of substance abuse/drug addiction
- ❑ Kidney problems
- ❑ Numbness of arms or hands
- ❑ Swollen, still painful joints
- ❑ Allergies
- ❑ Asthma
- ❑ Blood disease
- ❑ Diabetes
- ❑ Endocrine problems
- ❑ Intestinal disorders
- ❑ Hepatitis A, B, or C
- ❑ Hypertension (high blood pressure)
- ❑ Liver problems
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Anemia
- ❑ Bruise easily
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Seizures
- ❑ Fainting
- ❑ Hearing disorders
- ❑ High or low blood sugar
- ❑ Hypotension (low blood pressure)
- ❑ Nervous disorder
- ❑ Rheumatic fever
- ❑ Heart attack/stroke
- ❑ Heart surgery
- ❑ Pacemaker
- ❑ Artificial valves
- ❑ Congenital heart defect
- ❑ Mitral valve prolapse
- ❑ Artificial bones/joints
- ❑ Shingles
- ❑ HIV/AIDS
- ❑ Blood transfusions
- ❑ Fever blisters
- ❑ Sinus problems
- ❑ Severe/frequent headaches
- ❑ Cancer/chemotherapy
- ❑ Radiation treatments
- ❑ Psychiatric problems
- ❑ Tuberculosis
- ❑ Venereal disease
- ❑ Hemophilia
- ❑ Abnormal bleeding
- ❑ Ulcers/colitis
- ❑ Difficulty breathing
- ❑ Hospitalized for any reason
- ❑ Emphysema
- ❑ Glaucoma
- ❑ Thyroid disease
- ❑ Angina
- ❑ Artificial hip/joints
- ❑ Gout
- ❑ Chest pain
- ❑ Circulatory problems
- ❑ Cold sores
- ❑ Congenital heart lesion
- ❑ Cortisone medicine
- ❑ Convulsions
- ❑ Herpes
- ❑ Leukemia
- ❑ Excessive thirst
- ❑ Hay fever
- ❑ Heart disease
- ❑ Hives/skin rash
- ❑ Hypoglycemia
- ❑ Irregular heartbeat
- ❑ Lung disease
- ❑ Osteoporosis
- ❑ Pain in jaw joints
- ❑ Parathyroid disease
- ❑ Recent weight loss
- ❑ Rheumatism
- ❑ Scarlet fever
- ❑ Sexually transmitted disease
- ❑ Sickle cell anemia
- ❑ Sinus trouble
- ❑ Tattoos/body piercing
- ❑ TMD/TMJ (jaw pain)
- ❑ X-ray or cobalt treatment
- ❑ Yellow jaundice
- ❑ Chronic fatigue syndrome
- ❑ Cough-persistent or bloody
- ❑ Latex sensitivity
- ❑ Smoker
- ❑ Swelling of feet/ankles
- ❑ Swollen neck glands
- ❑ Tonsillitis
- ❑ Tumor or growth on head/neck
- ❑ Easily winded
- ❑ Anaphylaxis
- ❑ Alzheimer's disease
- ❑ Frequent diarrhea
- ❑ Genital herpes
- ❑ Renal dialysis
- ❑ Spina bifida

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

- ❑ Acrylic
- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Dental anesthetics
- ❑ Erythromycin
- ❑ Iodine
- ❑ Latex rubber
- ❑ Metals
- ❑ Nitrous oxide
- ❑ Novocaine
- ❑ Penicillin/antibiotics
- ❑ Sedatives
- ❑ Sulfa drugs
- ❑ Tetracycline
- ❑ Valium
- ❑ Xylocaine

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Are you being/have you ever been treated for cancer of any kind? If yes, please explain:
Yes

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). ❍Yes ❍No

Do you take or have you taken Phen-Fen or Redux? ❍Yes ❍No

Do you smoke or chew tobacco? ❍Yes ❍No

Do you use alcohol, cocaine, or other drugs? ❍Yes ❍No

Have you ever had any excessive bleeding requiring special treatment? ❍Yes ❍No

If female, please mark if you are:
❏ Pregnant - If so, please enter your due date or week #:
❏ Trying to get pregnant ❏ Nursing ❏ On birth control

Please list all current prescriptions:

All of the above information is correct to the best of my knowledge. 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. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

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HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Carnes Family Dental to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

If signing on behalf of someone, explain your relationship to the patient: