elite
The Pinnacle of Family & Cosmetic Dentistry

Patient Information

First Name: _____ **Last Name:** _____ **MI:** _____

Gender (circle): Male Female **Marital Status (circle):** Single Married Divorced Widowed

Birth Date: _____ **Social Security #:** _____

Employed by: _____ **Occupation:** _____

Patient Contact Information

Phone (Home): _____ **Phone (Cell):** _____ **Phone (Work):** _____

Email: Home Street Address: _____

City, State, Zip: _____

In case of emergency, who should be notified? _____

Spouse Information

Leave blank if you do not have a spouse

Spouse Name: _____ **Gender (circle)** Male Female **Social Security #:** _____

Phone (Home): _____ **Phone (Cell):** _____

Home Street Address (if different than own): _____

City, State, Zip: _____

Employer Name: _____ **Occupation:** _____

Parent or Guardian Information

Person responsible for the account/decisions – **leave BLANK if SELF**.

Relationship to the patient:_____

Name: _____ **Gender (circle):** Male Female

Marital Status (circle): Single Married Divorced Widowed

Birth Date: _____

Social Security #:_____

Phone (Home): _____ **Phone (Cell):** _____

Employer Name: _____ **Occupation:** _____

Provide below only if different from previous contact information.

Home Street Address:_____

City, State, Zip: _____

Second Parent or Guardian Information

Second Person responsible for the account/decisions – leave BLANK if SELF.

Relationship to the patient:_____

Name: _____ **Gender (circle):** Male Female

Marital Status (circle): Single Married Divorced Widowed

Birth Date: _____

Social Security #: _____

Phone (Home): _____ **Phone (Cell):** _____

Employer Name: _____ **Occupation:** _____

Provide below only if different than previous contact information.

Home Street Address (if different than own): _____

City, State, Zip: _____

Patient Dental Insurance Information

Is the patient covered by <u>Dental</u> Insurance? Circle): Yes No

Subscriber Name: _____ Relation to Patient: _____ Subscriber Birth Date: _____

Subscriber Address & Phone # (if different from patient/and not listed in Personal Information):

_____

Dental Insurance Company & Plan Type: _____

Dental Insurance Address & Phone # (Provider): _____

Subscriber Employed by/ Business Phone: _____

Dental Insurance Member ID # (listed on insurance card) or Social if no member ID provide: _____

Dental Insurance Group #: _____

Patient Secondary Dental Insurance information:

Is the patient covered by SECONDARY <u>Dental</u> Insurance? Circle): Yes No

Subscriber Name: _____ Relation to Patient: _____ Subscriber Birth Date: _____

Subscriber Address & Phone # (if different from patient/and not listed in Personal Information):

_____

Dental Insurance Company & Plan Type: _____

Dental Insurance Address & Phone # (Provider): _____

Subscriber Employed by/ Business Phone: _____

Dental Insurance Member ID # (listed on insurance card) or Social if no member ID provide: _____

Dental Insurance Group #: _____

Elite Dentistry Patient Financial Responsibility Form

Welcome to the dental office of Elite Family & Cosmetic Dentistry! We are committed to providing you with the highest quality dental care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.

We will bill patient's insurance as a service. However, the patient is required to provide the most correct and updated information regarding their insurance.

Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.

Copays are due at the time of service.

Coinsurance, deductibles and non-covered items not previously paid at time of service are due 30 days from receipt of billing from our office or in accordance to a formal agreement with our office.

Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:

- **Charge for returned checks - $30.00**
- **Missed appointment fee - $50.00**

By my signature below, I hereby authorize assignment of financial benefits directly to Kyle Thompson, DDS/Elite Family & Cosmetic Dentistry. I understand that I am financially responsible for charges not covered by this assignment. I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

Signature: _____ Date: _____

Dental History

Date of last dental care and former dentist: _____

Reason for today's visit: _____

Mark if you have had problems with any of the following:

❒Bad breath	**❒Bleeding gums**	**❒Clicking or popping jaw**
❒Food collection between teeth	**❒Grinding/clenching teeth**	**❒ Loose teeth or broken fillings**
❒Periodontal treatment	**❒Sensitivity to cold**	**❒Sensitivity to hot**
❒Sensitivity to sweets	**❒Sensitivity when biting**	**❒ Sores or growths in your mouth**

How often do you floss? _____

How often do you brush? _____

Have you had oral surgery? If yes, please list the procedures(s). _____

_____

_____

Do you have dental anxiety? If yes, please feel free to elaborate. _____

_____

_____

Medical History

Although dental personnel primarily treat your mouth and the areas around your mouth, health problems that you may have or medication that you may be taking could have an important relationship with the dental treatment that you receive. Thank you for answering the following questions:

Date of last Medical Exam: _____ Current Physician: _____ Physician Phone #: _____

Are you taking any medications or supplements? If yes, please list your medication(s). Y N **_____**

_____

_____

Have you ever been hospitalized or had a major operation? If yes, please list operation(s). Y N **_____**

_____

_____

Have you ever had a serious head or neck injury? If yes, please explain. Y N **_____**

_____

_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? If yes, was it oral or IV? _____

Are you on a special diet? Y N

Do you use tobacco? If yes, dip or smoke? Y N _____

Do you use controlled substances? If yes, what are they? Y N _____

Have you recently traveled outside of the country? If so, when? Y N _____

Allergies

Are you allergic to any of the following?

❒**Aspirin** ❒ **Penicillin** ❒ **Local Anesthetics**

❒**Codeine** ❒**Latex** ❒**Sulfa Drugs**

❒**Other (please list):** _____

Women

Skip if not applicable.

Are you pregnant or trying to become pregnant? Y N

Are you taking contraceptives? Y N

Are you nursing? Y N

Health History CONTINUED on NEXT PAGE→

For the following sections, please check all conditions that apply to you.

Orthopedic — Have/Had/Family History

- Artificial Joint ☐ ☐ ☐

Cardiovascular

- Angina (chest pain) ☐ ☐ ☐
- Artificial Heart Valve ☐ ☐ ☐
- /Prosthetic Implant ☐ ☐ ☐
- Heart Transplant ☐ ☐ ☐
- Infective Endocarditis ☐ ☐ ☐
- Congenital Heart Disorder ☐ ☐ ☐
- Heart Attack/Failure ☐ ☐ ☐
- Stroke ☐ ☐ ☐
- Heart Murmur ☐ ☐ ☐
- Heart Disease ☐ ☐ ☐
- High Blood Pressure ☐ ☐ ☐
- Irregular Heartbeat/AFIB ☐ ☐ ☐
- Pacemaker or Defibrillator ☐ ☐ ☐
- Mitral Valve Prolapse ☐ ☐ ☐
- Aneurysm ☐ ☐ ☐
- High Cholesterol ☐ ☐ ☐
- Rheumatic Fever ☐ ☐ ☐

Gastrointestinal

- Acid Reflux/GERD ☐ ☐ ☐
- Celiac Sprue ☐ ☐ ☐
- IBS/IBD ☐ ☐ ☐
- Hiatal Hernia ☐ ☐ ☐

Genitourinary/Reproductive

- Genital Herpes ☐ ☐ ☐
- Human Papilloma Virus (HPV) ☐ ☐ ☐
- Sexually Transmitted Diseases (STDs) ☐ ☐ ☐
- AIDS/HIV Positive ☐ ☐ ☐
- Kidney/Bladder Disease ☐ ☐ ☐
- Kidney Transplant ☐ ☐ ☐
- Frequent Urination ☐ ☐ ☐
- Renal Dialysis ☐ ☐ ☐
- Polycystic Ovary Syndrome (PCOS) ☐ ☐ ☐

Endocrine/Internal — Have/Had/Family History

- Diabetes ☐ ☐ ☐
- If yes, what type? _____
- If yes, what is you most recent A1C? _____
- Excessive Thirst ☐ ☐ ☐
- Fainting/Dizziness ☐ ☐ ☐
- Thyroid Disease ☐ ☐ ☐
- Pancreatitis ☐ ☐ ☐
- Swelling of Limbs ☐ ☐ ☐
- Hepatitis ☐ ☐ ☐
- If yes, which hepatitis? _____
- Liver Disease ☐ ☐ ☐
- If yes, which type? _____

Respiratory

- Asthma ☐ ☐ ☐
- If yes, do you have a rescue inhaler? If you do, when was it last used? _____
- Emphysema/COPD ☐ ☐ ☐
- Sleep Apnea ☐ ☐ ☐
- If yes, do you wear a c-pap? _____
- Tuberculosis ☐ ☐ ☐
- Allergies ☐ ☐ ☐
- If yes, are they seasonal or chronic? _____
- Chronic Bronchitis ☐ ☐ ☐

Mucoskeletal/Skin

- Canker Sores ☐ ☐ ☐
- Cold Sores/Fever Blisters ☐ ☐ ☐
- Oral Herpes ☐ ☐ ☐
- Arthritis/Gout ☐ ☐ ☐
- Corticosteroid Treatment ☐ ☐ ☐
- Hives or Rash ☐ ☐ ☐
- Rheumatoid Arthritis ☐ ☐ ☐
- Shingles ☐ ☐ ☐
- Osteoporosis/Osteopenia ☐ ☐ ☐
- Osteonecrosis ☐ ☐ ☐
- Lupus ☐ ☐ ☐

Neurologic — Have/Had/Family History

- ADD/ADHD ☐ ☐ ☐
- Alzheimer's Disease ☐ ☐ ☐
- Depression/Anxiety ☐ ☐ ☐
- Eating Disorder ☐ ☐ ☐
- Other Psychiatric Conditions ☐ ☐ ☐
- Epilepsy/Seizures ☐ ☐ ☐
- Glaucoma ☐ ☐ ☐
- Dementia ☐ ☐ ☐

Hematologic

- Hemophilia/Bleeding Disorder ☐ ☐ ☐
- Anemia ☐ ☐ ☐
- Blood Transfusion ☐ ☐ ☐
- Leukemia ☐ ☐ ☐
- Sickle Cell Disease ☐ ☐ ☐

Head/Neck/Throat/Mouth

- Difficulty Swallowing ☐ ☐ ☐
- Dry Mouth ☐ ☐ ☐
- Frequent Headaches ☐ ☐ ☐
- TMJ/Jaw Pain/Bruxism ☐ ☐ ☐
- Sinus Trouble ☐ ☐ ☐
- Enlarged Lymph Glands/Nodes ☐ ☐ ☐

Other

- Cancer ☐ ☐ ☐
- If yes, type? _____
- Chemotherapy ☐ ☐ ☐
- If yes, when? _____
- Radiation Treatment ☐ ☐ ☐
- If yes, when? _____
- Tumors/Growths ☐ ☐ ☐
- Addiction/Chemical Dependency ☐ ☐ ☐
- Alcoholism ☐ ☐ ☐
- Sjogren's Syndrome ☐ ☐ ☐
- Weight Loss ☐ ☐ ☐
- If yes, was it purposefully done? _____
- Anaphylaxis ☐ ☐ ☐

Have you ever had any illness or procedure not listed above including any long term effects from COVID-19? If yes, please explain.

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand 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: _____ Date: _____

HIPAA Notice of Privacy Practices Form

Point of Contact: 8780 US-42 B, Florence, KY 41042 - info@elitedentistrynky.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

_____

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Such uses or disclosures are:

• when a state or federal law mandates that certain health information be reported for a specific purpose;

• for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

• disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

• uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

• disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

• disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

• disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

• uses or disclosures for health related research;

• uses and disclosures to prevent a serious threat to health or safety;

• uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

• disclosures of de-identified information;

• disclosures relating to worker's compensation programs;

• disclosures of a "limited data set" for research, public health, or health care operations;

• incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

• disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. These reminders will typically go to any mobile number and/or email that we have on file, unless you tell us otherwise. If we see that your appointment has not been confirmed within two business days of your appointment, we will try calling you in order to confirm that appointment.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written authorization form. The content of an authorization form is determined by federal law.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing to our office.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

• ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To

ask for a restriction, send a written request to the office contact person at the address, fax or Email shown at the beginning of this notice.

• ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using Email to your personal Email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or Email shown at the beginning of this notice.

• ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or Email shown at the beginning of this notice.

• ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or Email shown at the beginning of this notice.

• get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or Email shown at the beginning of this notice.

• get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or Email shown at the beginning of this notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or Email shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

I hereby authorize the release of my Protected Health Information acquired in the course of my examination or treatment to my insurance company to secure payment for services. This information may be shared via written communication or electronic transmission, including emails without special encryption, to my insurance company. Further, I acknowledge and release my Protected Health Information to other dental service providers and specialist required to participate in my oral and overall healthcare.

Release of information is presumed if patient is under the age of 18 and/or under the care of a parent/guardian unless otherwise indicated.

Signature: _____ Date: _____

Additional Release of Information

I further authorize that the below-named parties to have access to my (or my child's) Protected Health Information and do acknowledge any party providing financial responsibility will have necessary and relevant access to my (or my child's) Personal Health Information and financial standing in the office:

Name: _____

Relationship to the patient: _____

Name: _____

Relationship to the patient: _____

Name: _____

Relationship to the patient: _____

Signature: _____ Date: _____

Final Authorizations: Initial each section below to indicate consent:

___ I authorize my insurance company to pay this dental office all insurance benefits otherwise payable to me/patient for services rendered.

___ I authorize the dental office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

___ I acknowledge that I have received the above financial policy. I understand that I am financially responsible for all charges whether or not paid by insurance.

___ I acknowledge that I have received the above copy of the HIPAA Policy.

___ I have read the above conditions of treatment and payment and agree to their content.

Relationship to Patient: _____

Signature: _____Date: _____