Louisville Dental Associates

PLEASE FILL OUT THE FORM COMPLETELY

INFORMATION

PATIENT NAME: _____

☐ MALE ☐ FEMALE Preferred Name: _____

Legal Guardian : _____ or ☐ SELF

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT DOB: ____/____/_____ PATIENT SSN: _____

EMAIL: _____

PHONE #1: _____ PHONE #2: _____

INSURANCE

GIVE YOUR CARD TO THE FRONT DESK

NAME OF INSURANCE: _____

NAME OF EMPLOYER: _____

PHONE NUMBER TO EMPLOYER: _____

NAME OF SUBSCRIBER: _____

SUBSCRIBER DOB: ____/____/____ SUBSCRIBER SSN: _____

MEMBER ID FROM CARD: _____

MEDICATION, ETC.

WHAT PHARMACY DO YOU USE? _____
*** DO YOU NEED A PRE MED BEFORE YOUR APPOINTMENTS? _____

ARE YOU OR COULD YOU BE PREGNANT? _____ BREASTFEEDING? _____
IF SO, DOCTOR: _____ PHONE: _____
ARE YOU TAKING ANY FORM OF BIRTH CONTROL? _____
PLEASE NOTE ANYTIME YOU ARE GIVEN ANTIBIOTICS OR PAIN MEDICATION THIS CAN AFFECT YOUR BIRTH CONTROL AND BREASTFEEDING!

MEDICATIONS: *(LIST ALL – If you do not know the name, list the reason for the medication.)*
IF YOU HAVE A LIST OF YOUR MEDICATIONS, THE STAFF WOULD BE HAPPY TO MAKE A COPY OF IT FOR YOUR FILE.
TAKE IT TO THE FRONT DESK.

* _____	* _____
* _____	* _____
* _____	* _____
* _____	* _____

ALLERGIES:

☐ Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Latex

LIST OTHER ALLERGIES: _____

Medical Issues & Problems: PLACE AN "X" BY THE ITEMS THAT DESCRIBE YOUR MEDICAL HISTORY

- ○ Artificial Joints/Bones: _____
- ○ CANCER OR CHEMO/RADIATION, ETC
- ○ High or Low Blood Pressure
- ○ HEPATITIS _____
- ○ Sinus Problems
- ○ Heart (Pacemaker, Stents, Murmur, Surgeries-List all)
- ○ Seizures
- ○ Diabetes
- ○ HIV/AIDS
- ○ Headaches/Migraines

_____

OTHER: _____

_____

PLEASE LIST ANY SURGIES OR OTHER HISTORY YOU HAVE AND
LIST YOUR DOCTOR'S NAME ON THE LINE ABOVE IF YOU ARE ON A BLOOD THINNER
OR THERE IS ANOTHER REASON TO CALL.

SIGNATURE PAGE

The paperwork you have completed is necessary for efficient and effective treatment at this practice. Any attempt at fraud involving the information on this paperwork can result in legal action. Also, please note that this office abides by the Health Insurance Portability and Accountability Act of 1996 "HIPAA". If you wish to have a full copy of your HIPAA information, please ask the front desk. Your signature below states that you have completed this form accurately, and that you understand your HIPPA rights.

X _____ Date: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS UNDER 18 OR NOT ABLE TO CONSENT ALONE

IF YOU WISH TO RELASE YOUR INFORMATION TO A THIRD PARTY PLEASE LIST THE PERSON(S) OR PLACE(S) HERE: _____

If you are not the person responsible for payment on this account, please list the information below: PERSON RESPONSIBLE FOR CHARGES:

_____

ADDRESS TO MAIL STATEMENTS:

_____

City_____ **State**_____ **Zip**_____

PHONE NUMBER TO RESPONSIBLE PARTY: _____

YOUR RELATIONSHIP TO THE RESPONSIBLE PARTY: _____

This office processes insurance claims for your treatment on your behalf and insurance payments are to be sent to the office. If for any reason, the insurance company sends the payment to you, this office should be notified immediately. The quotes given in the office are based on the assumption that the insurance company will be sending the payment to LOUISVILLE DENTAL ASSOCIATES. The signature below authorizes this office to release information necessary to process dental claims, and your signature authorizes the payment of the dental benefits, otherwise payable to you, to be paid to the provider of services for the treatment received at this practice. YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED.

X _____ Date: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS UNDER 18 OR NOT ABLE TO CONSENT ALONE

The United States Drug Enforcement Administration companied with the Board of Dental Examiners both have strict regulations about the type of medications a patient receives. The abuse of medications by a provider can result in the revocation of the license as well as fines and penalties. This situation is one we take very seriously at this practice, and we have set new guidelines on the amount of medication given. Once you have been notified of the treatment needed and/or the infection present, it is your responsibility to see that the treatment gets done. Patients will not be written multiple prescriptions for the same problem area. Your signature below confirms you have read and understood the policy.

X _____ Date: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS UNDER 18 OR NOT ABLE TO CONSENT ALONE

Thank you for allowing Louisville Dental Associates to take care of your smile.

-Owners, Tony & Kimberly Faulk