Hebron Advanced Dentistry

First name: _____

Last name: _____

_____

What name does the patient prefer to go by? _____

Birth date: _____

Gender:_____

SSN: _____

Email address: _____

Phone number: _____

Address line 1:_____

Address line 2: _____

City: _____

State: _____ Postal code: _____

How did you hear about us? _____

Employment Details:_____

Occupation: _____How long? _____

Employer name: _____

Please list 2 contact names to whom practice can release PHI information (HIPAA):

Name _____ Phone Number _____

Name _____ Phone Number _____

Emergency Contact: _____

Name _____ Phone Number _____

Signature: _____Date: _____

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Hebron, KY 41048
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Dental Insurance

Name of insured_____

Insured's birth date _____

Insured's address line 1 _____

Insured's address line 2_____

Insured's city _____

Insured's state _____

Insured's postal code _____

Patient's relationship to insured_____

Insured's employer name _____

Employer's address line 1 _____

Employer's address line 2_____

Employer's city _____

Employer's state _____

Employer's postal code _____

Carrier name _____

Plan name_____

ID #_ _____

Group # _____

Insurance company phone number _____

Insurance's address line 1_____

Insurance's address line 2_____

Insurance's city _____

Insurance's state_____

Insurance's postal code_____

If you have secondary insurance, please ask for another form

Signature_____**Date:** _____

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Medical History Form

Name _____Date of Birth_____

Allergy to Aspirin : YES / NO
Allergy to Codeine : YES / NO
Allergy to Latex : YES / NO
Allergy to Local Anesthetic : YES / NO
Allergy to Penicillin : YES / NO
Allergy to Sulfa : YES / NO
List any other allergies : _____

High Blood Pressure : YES / NO
Low Blood Pressure : YES / NO
AIDS/HIV : YES / NO
Anemia / Bleeding Problems : YES / NO
Artificial Heart Valves : YES / NO
Blood Disease : YES / NO
Congenital Heart Lesions : YES / NO
Heart Problems : YES / NO
Pacemaker : YES / NO
Arthritis / Rheumatism / Gout : YES / NO
Artificial Joints / Bones : YES / NO
Asthma : YES / NO
Cancer : YES / NO
Chemotherapy : YES / NO
Diabetes : YES / NO
Emphysema : YES / NO
Glaucoma : YES / NO
Radiation Treatment (X-Ray/Cobalt) : YES / NO
Shortness of Breath (Breathing Problems) : YES / NO
Sinus Trouble : YES / NO
Stroke : YES / NO
Thyroid Problems : YES / NO

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Tuberculosis : YES / NO

Tumor / growth on head / neck : YES / NO

Ulcer : YES / NO

Epilepsy : YES / NO

Fainting / Dizziness : YES / NO

Headaches (Frequent) : YES / NO

Hepatitis : YES / NO

Herpes : YES / NO

Kidney Disease : YES / NO

Liver Disease : YES / NO

Nervous Problems : YES / NO

Psychiatric Care : YES / NO

High Cholesterol : YES / NO

List any other medical issues you have_____

_____

List any serious Illnesses / surgeries / hospitalizations_____

_____

List any medications you are taking_____

_____

Pregnant : YES / NO Weeks: _____

Nursing : YES / NO

Do you smoke: YES / NO

Do you drink alcohol: YES / NO Frequency: _____

Do you have a high sugar intake diet: YES / NO

Are you under the care of a primary care physician?

Dr. Name _____ Dr. Phone Number _____

Signature_____**Date:** _____

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Dental History Form

Reason for visit: _____

Date of last dental visit: ____ 0-6 months ____ 6 months-1 year ago

____ 1-2 years ago ____ More than 2 years ago

Date of last dental x-rays: Month _____ Day _____ Year _____ (approximately)

How often do you floss? __2-3 times a day ___ 2-3 times a week ___Daily __ Never

How often do you brush? __2-3 times a day ___ 2-3 times a week ___Daily __ Never

Bad Breath: YES / NO

Bleeding, Red, Swollen Gums: YES / NO

Broken/Loose teeth or fillings: YES / NO

Clicking or popping jaw: YES / NO

Grinding teeth: YES / NO

Pain around ear/side of face: YES / NO

Sores/Blisters in mouth: YES / NO

List any other dental concerns/pain _____

What did you like the most about your previous dental office?

_____

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What did you like the least about your previous dental office?

_____

Are you interested in whitening your smile? YES / NO

Are you happy with your smile? If not, what would you change?

_____

Signature_____**Date:** _____

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Financial Policy/HIPAA/Assignment of Benefits

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality of care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. Our fees are based on the quality materials we use and the time, effort, and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help achieve oral health. Ultimately, however, you are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive full benefits of your policy by electronically filing your claim the day of your appointment. We accept the following forms of payment: Cash, Check, Visa, Mastercard, Discover, and American Express. In addition, we offer CareCredit and Lending Club, these are patient payment programs offering a full range of Extended Payment Plans. Payment for services is due at the time of services are rendered unless prior arrangements have been made. Checks that are returned to our office from your financial institution are subject to a $50.00 returned check fee. This fee covers the processing fees that are charged to our office. Refunds for overpayment will be sent after all treatment is completed and insurance has been collected. Our practice is dedicated to quality care and exceptional service. Our doctor and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other patients. If you find that you must change your appointment, we require a minimum of 48 hours notice so that we may make every effort to accommodate other patients. If proper notice is not received there is a one time courtesy for not showing up for a scheduled appointment. Repeated cancellations or missed appointments will result in a fee of $50.00.

I have read and agree to the Financial Policy and the Cancellation Policy of Hebron Advanced Dentistry.

Acknowledgement of Receipt of HIPPA Notice of Privacy

I hereby acknowledge that I have received and reviewed a copy of Hebron Advanced Dentistry HIPPA Notice of Privacy Practices. I understand that Hebron Advanced Dentistry's HIPPA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of

Hebron Advanced Dentistry's HIPPA Notice of Privacy Practices, I may contact Hebron Advanced Dentistry. I understand that it is my right to refuse to sign the Acknowledgment should I choose, and that Hebron Advanced Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgment. I further understand that I may contact the Secretary of the U.S Department of Health and Human Services should I have concerns regarding Hebron Advanced Dentistry's privacy policies and procedures. For how to contact the U.S. Department of Health and Human Services, please Hebron Advanced Dentistry for more information.

Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Hebron Advanced Dentistry.

Medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or the agreed amount for services rendered.

Authorize to Release Information

I hereby authorize Hebron Advanced Dentistry To: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) Process insurance claims generated in the course of examination or treatment; and (3) Allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me writing. I have requested medical services from: Hebron Advanced Dentistry On behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I hereby affirm that any payment made to me by the insurance carrier will immediately be transferred to Hebron Advanced Dentistry. Upon receipt for services rendered. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement EOB or check.

Signature _____ Date _____