The Center for Aesthetic & Implant Dentistry

DAVID C. JONES, DMD
12010 Shelbyville Rd.
Louisville, Kentucky 40243
tel 502-589-4671 / fax 502-589-6584
SmileLouisville.com

Confidential Patient Information

(Please Print Legibly)

Date _____

Personal Information

First Name _____ Last Name _____

SSN _____

Address _____

City _____ State _____ Zip _____

Telephone (Home)_____ (Work) _____ (Mobile) _____

Email _____ Date of Birth _____ Sex _____

Marital Status _____ Spouse Name _____

Employer _____ Referred By _____

Person Responsible for Account

Name _____ Relationship _____ SSN _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____

Dental Insurance Information

Primary lnsurance Company _____

Insurance CompanyAddress _____

Policy Holder _____ Relationship _____ SSN _____

Employer: _____ Policy Number _____

Secondary Insurance Company _____

Insurance Company Address _____

Policy Holder _____ Relationship _____ SSN _____

Employer _____ Policy Number _____

I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature _____ Date _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

First Name _____ Last Name _____

Address _____

Telephone _____ Email _____

Patient Number _____ Social Security Number _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issu e a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting.

This office at 12010 Shelbyville Road, Suite 100
Phone: (502) 589-4671 Fax: (502) 589-6584

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature _____ Date _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representatives Name _____

Relationship to Patient _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the Patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature _____ Date _____

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MEDICAL HISTORY QUESTIONNAIRE

First Name: _____ Last Name _____ Date _____

Date of Birth: _____ Age: _____ Sex: _____ Height _____ Weight _____

For the following questions, circle or select YES or NO, whichever applies.
Your answers are for our records only and will be kept confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. Physician Name _____ Phone _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
   Please explain _____
   _____
7. Have you had an artificial joint replacement (knee, hip, etc.)? What year? ..... Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia)? Please circle one if yes ..... Yes No

9a. Are you taking any blood thinners? (Xarelto, Coumadin, Plavix, Pradaxa, Aggrenox, Aspirin) Please circle one if yes ..... Yes No

9b. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? ..... Yes No
   If so, please list _____
   _____
   _____
   _____

10. Do you have or have you had any of the following diseases or problems? If yes, please explain
    a. Artificial valves, heart murmur, or mitral valve prolapse ..... Yes No
    b. Rheumatic Heart Disease, damaged heart valves ..... Yes No
    c. Heart trouble, heart attack, angina, stroke, arteriosclerosis or any other heart condition ..... Yes No
       1. Chest pain upon exertion? ..... Yes No
       2. Shortness of breath after mild exercise? ..... Yes No
       3. Do your ankles swell? ..... Yes No
    d. High Blood Pressure ..... Yes No
    e. Sinus trouble ..... Yes No
    f. Asthma ..... Yes No
    g. Fainting spells or seizures ..... Yes No
    h. Diabetes ..... Yes No
    i. Hepatitis, jaundice or liver disease ..... Yes No
    j. Frequent or recurring mouth sores ..... Yes No
    k. Thyroid problems ..... Yes No
    l Respiratory problems, emphysema, bronchitis, COPD ,etc. ..... Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
    n. Osteoporosis ..... Yes No
    o. Stomach ulcer or colitis ..... Yes No
    p. Kidney disease ..... Yes No
    q. Tuberculosis ..... Yes No
    r. Persistent cough or cough that produces blood ..... Yes No
    s. Persistent swollen neck glands ..... Yes No

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t. Low blood pressure ..... Yes No
u. Epilepsy or neurological disorder ..... Yes No
v. Cancer ..... Yes No
w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No

11. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
12. Do you have any blood disorder such as anemia? ..... Yes No
13. Have you ever had treatment for a tumor or growth? ..... Yes No
14. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Other *(please list name of medication)* ..... Yes No
16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain _____
17. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain _____
18. Do you smoke or chew Tobacco? ..... Yes No
    How much? _____ How long ? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes No
20. Are you wearing contact lenses? ..... Yes No
21. Are you wearing removable dental appliances? ..... Yes No
22. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

Are you pregnant or any chance you might be pregnant? ..... Yes No

Are you nursing? ..... Yes No

Are you taking birth control pills? (If so, antibiotics and some other medications may interfere with the effectiveness of birth control. Consult with your physician.) ..... Yes No

Chief Dental Complaint

_____

_____

_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient's Signature _____ Date _____

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INFORMATION FOR OUR PATIENTS WITH DENTAL INSURANCE

Dental insurance is playing a larger and larger role in helping people obtain dental treatment. Since we feel strongly that our patients deserve the best dental care we can provide, and in effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

We consider our relationship with you to be of primary importance and will always make our recommendations to you based on what we believe is the very best treatment for you regardless of your insurance coverage. As the patient, it is your responsibility to deal with your insurance company and your employer. We will assist in any way possible to maximize your dental insurance benets, but to reemphasize. We have no relationship or responsibility to your insurance company.

FACT #1 Dental insurance is not meant to be PAY-ALL i,t is only meant to be an aid.

FACT #2 Many plans tell their insured that they will be covered up to 80% or up to 100%. In spite of what you are told, we have found many plans cover 40% to 50% of an average fee. Some plans pay more some pay less. The amount your plan pays is determined by the contribution you and your employer make to your dental plan. The smaller the contribution paid into the plan for insurance, the less you will receive. It is your responsibility to advise us of your insurance coverage restrictions.

FACT #3 It has been the experience of many dentists that some insurance companies tell their customers that fees are above the usual and customary fees rather than saying to them that our benets are low. Remember, you get back only what you and your employer put into your insurance coverage less the prots of the insurance company. In dealing with over 1,000 dental insurance plans, most plans do cover our fee.

FACT #4 Each plan utilized in our ofce has different percentages, deductibles, maximums, procedures covered, and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible of what your insurance plan will cover. However, we cannot estimate precisely. There may be variances for what the patient is individually responsible.

FACT #5 Insurance carriers do NOT cover many routine dental services. We make our recommendations based on your needs and not on what your insurance may or may not cover.

Please do not hesitate to ask us any questions about our ofce policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. We will ll out and le insurance forms at no charge. We will do all we can to assure you of your maximum benets.

If you have any questions regarding your insurance, please contact your insurance carrier regarding the specics and details of the plan they are operating on your behalf.

- ☐ I authorize the release of all necessary information
- ☐ I authorize payment of benets directly to the provider
- ☐ I have read this form and agree to be nancially responsible for all fees regardless of insurance coverage

Signature _____ Date: _____

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Medical Records Release Form

I _____ authorize the release of information concerning dental care history for the following patient(s) to the office below:

Patient(s) First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Date(s) of Birth _____

Transfer Records to:

Dental Office Name: David C. Jones, D.M.D.

Address: 12010 Shelbyville Rd. Ste. 100

City, State, Zip: Louisville, KY 40243

Telephone: (502) 589-4671

E-mail Address: SmileLouisville@yahoo.com

Patient or Gaurdian Signature _____ Date _____

Office Signature _____ Date of Transfer _____

**Please fax or mail this form to David C. Jones, D.M.D.*

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DIRECTIONS