*Computer Users: Download & open in Acrobat before filling out **Phone Users: Download Adobe Acrobat Reader app

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PEBBLE CREEK FAMILY DENTISTRY

PATIENT INFORMATION...

Date _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ☐ Male ☐ Female Birth Date _____ Age ____ Soc. Sec. # _____ E-mail _____

Street _____ Apt. ____ City _____ State ____ Zip _____

Home Tel.(____) _____ Cell.(____) _____ Have you ever been a patient of our practice? ☐ Yes ☐ No

Referred By _____ (FIRST NAME / LAST NAME) Has a family member ever been a patient of our practice? ☐ Yes ☐ No

Dentist _____ (FIRST NAME / LAST NAME) Medical Doctor _____ (FIRST NAME / LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME / LAST NAME) Tel.(____) _____

Employer _____ Bus. Tel.(____) _____ Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card

In case of emergency, please contact _____ Tel. (____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Name _____ (FIRST NAME / LAST NAME) S.S.# _____ Birth Date _____ Age ____ Tel.(____) _____

Street _____ Apt. ____ City _____ State ____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel.(____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name _____ Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. ____ City _____ State ____ Zip _____

Tel. (____) _____ Employer _____ Bus. Tel.(____) _____

INSURANCE INFORMATION...

Student: ☐ Full Time ☐ Part Time ☐ Not School Name and Address _____

Marital Status: ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated _____

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Do you belong to a PPO or HMO? ☐ Yes ☐ No

PRIMARY INSURANCE COMPANY...

Employer _____ Bus. Tel.(____) _____

Ins. Co. Name _____ I.D. # _____

Insured Party _____ Relation _____

Birth Date _____ S.S. # _____

SECONDARY INSURANCE COMPANY...

Employer _____ Bus. Tel.(____) _____

Ins. Co. Name _____ I.D. # _____

Insured Party _____ Relation _____

Birth Date _____ S.S. # _____

DENTAL INFORMATION...

Reason for today's visit _____ Are you in pain? ☐ Yes ☐ No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

- ☐ Discomfort, clicking, or popping in jaw
- ☐ Red, swollen, or bleeding gums
- ☐ A removable dental appliance
- ☐ Blisters / sores in or around the mouth
- ☐ Prolonged bleeding from an injury / extraction
- ☐ Recent infections or sore throat
- ☐ My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting
- ☐ Lost / broken filling(s)
- ☐ Teeth grinding / clenching
- ☐ Ringing in ears
- ☐ Broken / chipped tooth
- ☐ Gum disease
- ☐ Other _____
- ☐ Stained teeth
- ☐ Locking jaw
- ☐ Bad breath
- ☐ Burning tongue / lips
- ☐ Toothache
- ☐ Difficulty closing jaw
- ☐ Difficulty opening jaw
- ☐ Loose / shifting teeth
- ☐ Food caught between teeth
- ☐ Swelling / lumps in mouth

Last dental exam _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ☐ Yes ☐ No

What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

PHOTOGRAPHIC RELEASE...

I, _____ hereby authorize Pebble Creek Family Dentistry, PLLC to take photographs of my face, jaws and teeth. These will be used for my dental record. I understand that my record remains private and anonymous. Occasionally these photos may be used for educational purposes or advertising (including website, newspaper, lecture, etc.). If used for these publications, my privacy and anonymity is maintained. I do not expect compensation for use of the photos of Dr. Segebarth, Dr. Spencer or Dr. King's dental work.

Patient Name: _____ Signature: _____ Date: _____

MEDICATION & ALLERGIES...

Are you currently taking, or have you recently taken, the following:

Y N
- ☐☐ Nerve pills
- ☐☐ Diet pills
- ☐☐ Blood thinners (Coumadin, Aspirin, Advil)
- ☐☐ Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)
- ☐☐ Pre-medication prior to dental appointments.

Y N
- ☐☐ Pain killers (including aspirin)
- ☐☐ Tranquilizers

Y N
- ☐☐ Muscle relaxers
- ☐☐ Insulin

Y N
- ☐☐ Stimulants
- ☐☐ Antidepressants

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or have you had a reaction to:

Y N
- ☐☐ Penicillin / Amoxicillin
- ☐☐ Valium / other tranquilizers
- ☐☐ Soy

Y N
- ☐☐ Sulfa drugs
- ☐☐ Aspirin
- ☐☐ Eggs / Yolk

Y N
- ☐☐ Local anesthetic (numbing med)
- ☐☐ Codeine or other narcotics
- ☐☐ Latex

Y N
- ☐☐ Erythromycin
- ☐☐ Tetracycline
- ☐☐ Metals / non-precious metals

Please list any other medication or antibiotic you are allergic to: _____

Please list any allergies other than drug allergies: _____

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ☐Yes ☐No
2) Expected delivery date: _____
3) Are you nursing? ☐Yes ☐No
4) Are you taking birth control pills: ☐Yes ☐No

MEDICAL HISTORY...

Are you in good health? ☐Yes ☐No Height _____ Weight _____ Are you under the care of a physician? ☐Yes ☐No

Have you had any illness, operation, or been hospitalized in the past five years? ☐Yes ☐No

Physician's Name _____ Tel. (___) _____ Preferred Pharmacy _____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y N
RESPIRATORY
- ☐☐ Pneumonia / Bronchitis / Chronic cough
- ☐☐ Asthma
- ☐☐ Hay fever / Sinus problems
- ☐☐ Snoring / Sleep apnea
- ☐☐ Respiratory problems
- ☐☐ Tuberculosis
- ☐☐ Emphysema
- ☐☐ Do you smoke; if so, # packs a day____
- ☐☐ Do you use chewing tobacco

CIRCULATORY
- ☐☐ Blood transfusion
- ☐☐ Blood disorder / Anemia
- ☐☐ Bruise easily
- ☐☐ Abnormal bleeding

Y N
NEUROLOGICAL
- ☐☐ Stroke
- ☐☐ Fainting spells
- ☐☐ Seizures / Epilepsy
- ☐☐ Tourette syndrome
- ☐☐ Mental health problems

ORGAN SYSTEMS
- ☐☐ Kidney trouble
- ☐☐ Are you taking dialysis?
- ☐☐ Jaundice / Liver disease
- ☐☐ Hepatitis
- ☐☐ Gallbladder trouble
- ☐☐ Stomach ulcers
- ☐☐ Eye disease / Glaucoma

Y N
HEART
- ☐☐ Mitral valve prolapse
- ☐☐ Damaged heart valves
- ☐☐ Heart murmur
- ☐☐ High / low blood pressure
- ☐☐ Chest pain / Angina
- ☐☐ Heart attack(s)
- ☐☐ Irregular heart beat
- ☐☐ Cardiac pacemaker
- ☐☐ Heart surgery
- ☐☐ Trouble climbing 1-2 flights of stairs
- ☐☐ Swollen ankles

Y N
BONE / ENDOCRINE
- ☐☐ Thyroid trouble
- ☐☐ Diabetes
- ☐☐ Low / high blood sugar
- ☐☐ Arthritis / Joint disease
- ☐☐ Osteoporosis
- ☐☐ Osteonecrosis
- ☐☐ Artificial bones / Joints / Valves

GENERAL HEALTH
- ☐☐ History of drug / alcohol abuse
- ☐☐ Sexually transmitted disease(s)
- ☐☐ Are you immunosuppressed?
- ☐☐ Chronic fatigue / night sweat
- ☐☐ Delay in healing
- ☐☐ Tumor or growth
- ☐☐ Cancer / Radiation / Chemotherapy

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*
X _____ **Reviewed by**
X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*
X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)*
X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if minor)*
X _____ **Date**

Pebble Creek Family Dentistry
2100 N Main Street Madisonville KY 42431
270-825-2686
www.pebblecreekdentistry.com

Thank you for choosing Pebble Creek Family Dentistry. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your dental treatment. Your estimated portion of treatment is due at the time of service. We accept all of the following: Cash, personal check, MasterCard, American Express, Discover, Visa, Money Order, and Care Credit.

What is your preferred method of payment at the time of service? _____

Regarding Dental Benefits

As a courtesy, we prepare and electronically submit all necessary forms to your dental benefit administrator. Our estimate of your out of pocket costs will take those benefits into consideration. Please remember, we cannot guarantee the amount of your benefit and there may be a remaining balance that you are responsible for. We may accept assignment of insurance benefits, however, the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 60 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

Please note:

For longer, more comprehensive appointment times of 2 hours or longer, a $50.00 deposit is required to secure your treatment appointment. This deposit becomes non-refundable if you cancel or reschedule your appointment less than 24 hours prior to your appointment time.

Our returned check fee is $45.00

I understand that if my account reaches collection status and I make no effort to pay off my account in full, my account will be assigned to a collection attorney. If the attorney must take additional steps to collect my account, I will pay ALL costs of collection, including court costs and attorney's fees incurred by the account.

Thank you for reading our Financial Philosophy. Please let us know if you have any questions or concerns.

I have read the Financial Philosophy. I understand, accept, and agree to this Financial Philosophy.

_____ _____

Signature of Patient/Responsible Party Date

NOTICE OF PRIVACY PRACTICES

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

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us in writing how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us in writing how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Ask us in writing how to do this.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the last page of this Notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Contact Information

Business Support :: (714) 578-6487 :: Monday – Friday 8:00 a.m. to 5:00 p.m. Pacific Time

Effective Date – October 1, 2016

Chart # _____

Patient Acknowledgement of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me.

_____ _____
Patient's Signature Date

_____
Print Legal Guardian's Name (if patient is a minor)

_____
Legal Guardian's Signature

Click SUBMIT button to send your completed form to our office:

SUBMIT

For office use only:

☐ Patient refused a copy of the Notice of Privacy Practices (NPPs).
☐ Patient refused to sign Acknowledgement of NPPs.

_____ _____
Print Name (office staff) Date

_____
Signature

Place the completed copy in the patient's chart.