DCOF
Dental Center of Florence

8076 U.S. HWY 42
Florence, KY 41042
Phone 859-282-9741
Fax 859-282-2171
www.DCOF.com

Patient Information

Name _____
Birth Date _____
Driver's License # _____
Street Address _____
City _____
State _____ Zip _____
Home Phone _____
Cell Phone _____
Email _____

☐ Male ☐ Female ☐ Prefer not to answer
☐ Child ☐ Single ☐ Married ☐ Widowed

Person to Contact in Emergency:
Name _____
Phone _____

Social Security # _____
Employer _____
Work Phone _____
Employer Address _____
City _____
State _____ Zip _____
Spouse or Parents Name _____
Date of Birth _____

Who referred you to DCOF?
☐ Event ☐ Location ☐ Website ☐ Commercial
☐ Radio ☐ Tank Bus ☐ Family/Friend

Responsible Party

Name _____
Relationship to Patient _____
Street Address _____
City _____
State _____ Zip _____
Is this person a current patient of DCOF? ☐ Yes ☐ No

Home Phone _____
Cell Phone _____
Driver's License # _____
Employer _____
Work Phone _____
Signature _____

Insurance Information

Name of Insured _____
Relationship to Patient _____
Date of Birth _____
Social Security # _____
Employer Name _____
Insurance Company _____
Group # _____
Insurance Phone # _____

Additional Insurance ? ☐ Yes ☐ No
Name of Insured _____
Relationship to Patient _____
Date of Birth _____
Social Security # _____
Employer Name _____
Insurance Company _____
Group # _____
Insurance Phone # _____

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Policies

Thank you for choosing the Dental Center of Florence as your dental healthcare provider. We are committed to providing you with the highest quality dental care. This form supersedes any previous financial/appointment policies.

INSURANCE: If you have dental insurance, please bring your current dental insurance information with you to your appointment. Please notify our office prior to treatment of any changes in your: dental insurance plan, home address, phone numbers, email address, etc. We file your insurance claims as a courtesy to you as your insurance is a contract between you and your insurance carrier. We will not deny care due to uncertainty as to the participation status of the providers at the Dental Center of Florence with your insurance plan. If we are not part of your plan, your responsibility for fees may be greater. We ask that you sign this form or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. You are also authorizing the release of any information concerning your (or your minor's) care and treatment provided for the purpose of evaluating and administering claims for insurance benefits. We will ask you to contact your insurance company, if the payment has not been received in 60 days from the date it was filed. If your claim is denied you will be responsible for paying the full amount at that time.

MULTIPLE INSURANCE PLANS: If you have more than one insurance plan it is your responsibility to see that the plans are coordinated appropriately. Any Coordination of Benefits (COB) issues are the patient's responsibility. If the patient doesn't resolve a COB issue the outstanding balance will be due and payable by the patient.

INSURANCE ESTIMATES: Please understand that we provide an insurance estimate to you. Estimates are not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to: limitations, frequency, exclusions, age restrictions, waiting periods, and maximums which are your responsibility. We ask that prior to or at the time of service.

MINORS: The parent or legal guardian accompanying the minor, who has consented to the treatment, is responsible for full/estimated payment at the time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

APPOINTMENT POLICY: There is a minimum notice of 24 hours required for cancelling an appointment or rescheduling an appointment. Appointments must be cancelled or rescheduled during normal business hours Monday-Friday. Voicemail messages are not permitted. Please be advised that should you not provide adequate notice or not show up for your scheduled visit a fee will be assessed. This fee would need to be paid prior to being placed back on the schedule. This fee is not covered by your insurance and is not refundable. We reserve the right to release you from our practice for failure to show up for scheduled treatment.

APPOINTMENT DEPOSITS: Depending on the appointment type you may be required to place a deposit at the time the appointment is scheduled. The deposit will be applied to the treatment balance if you show up for the scheduled treatment. If you no show or late cancel these deposits are not refundable and will not be applied to any other treatment.

REFUNDS: Any refunds will be placed back on the original form of payment.

CONSENT: I have read, understand and agree to the above terms and conditions. I understand that I am financially responsible for all charges incurred for services rendered to the patient listed below, myself, or a minor under the care of the Dental Center of Florence. I agree to be responsible for all appropriate: co-pays, deductibles, coinsurance, denied charges or expulsions listed in the policy.

PATIENT/PARENT PRINTED NAME _____

PATIENT/PARENT SIGNATURE _____ **DATE** _____

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Medical History

Patient Name _____

Primary Physician Name _____

Physician Phone _____ Date of Last Exam _____

Pharmacy _____ Pharmacy Phone _____

List all Medications (include over-the-counter): ☐ No Medications

_____

_____

Have you ever in the past, or are you now currently, taking any medications for Osteopenia/Osteoporosis or Bone Disease?

☐ Yes ☐ No If yes, please list medications _____

	Y	N
Do you drink alcohol?	☐	☐
Do you use tobacco/smoking/vaping?	☐	☐
Do you have a history of substance abuse?	☐	☐
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐

List all allergies: ☐ No allergies

	Y	N
Penicillin	☐	☐
Sulfa	☐	☐
Latex	☐	☐
Codeine	☐	☐
Lidocaine	☐	☐

Please check to indicate if you have or have had any of the following:

Cancer (Type _____)
- ☐ Chemotherapy
- ☐ Radiation Therapy

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Artificial Heart Valve
- ☐ Heart Condition
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Pacemaker
- ☐ Stroke

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood Disorders
- ☐ Bruise Easily
- ☐ Excessive Bleeding

Musculoskeletal
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Jaw Joint Pain
- ☐ Rheumatoid Arthritis

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Drug/Alcohol Addiction
- ☐ Fainting
- ☐ Seizures
- ☐ Psychiatric Illness

Gastrointestinal
- ☐ Ulcers (Stomach)
- ☐ Gastrointestinal Disease

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Tuberculosis

Viral Infections
- ☐ AIDS
- ☐ HIV Positive
- ☐ HPV
- ☐ HSV-1

List any other conditions / details / explanations _____

_____

_____

Dental History

On a scale of 1 – 10, with 10 being the highest:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where do you want your dental health to be?	1	2	3	4	5	6	7	8	9	10

What would you like to change about your smile? (Check all that apply)

☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party mayors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT OR GUARDIAN _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Policy provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are now required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation is not retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or sent texts to you to confirm appointments? ☐ Yes ☐ No

May we leave a message on your answering machine at home or on your cell phone? ☐ Yes ☐ No

May we discuss your medical condition with any member of your family? ☐ Yes ☐ No

If yes, please name the members allowed:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Print Your Name _____

Signature _____ Date _____

Witness _____ Date _____