PATIENT INFORMATION

patient's name _____ DOB _____ SS# _____

address _____

city _____ state _____ zip _____

home phone _____ work phone _____ cell phone _____

place of employment _____

spouse's name _____ place of employment _____

account's responsible party _____

In case of emergency, whom shall we notify other than your spouse? _____

name _____ relationship _____ phone _____

Who may we thank for referring you to our office? _____

DENTAL HISTORY

Date of last cleaning _____ Do your gums bleed? ❑ yes ❑ no

Do you experience any pain from heat or cold? ❑ yes ❑ no

Have you had an allergic reaction to **Latex**? ❑ yes ❑ no **local anesthesia**? ❑ yes ❑ no

List any specific dental problems:

MEDICAL HISTORY

physician's name _____ phone _____

address _____ city _____ state _____ zip _____

MEDICAL HISTORY [cont'd]

Are you seeing a physician at the present time for the treatment of a recent or ongoing medical condition? If yes, list reason(s):

Have you had a serious illness or surgery within the last year? If so, please list:

Are you allergic to any medications. If so, please list:

List any medications you currently take:

DO YOU NOW OR HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

❑ yes ❑ no Do you take Aspirin, Coumadin, Warfarin, Plavix or any blood thinners? If yes, please list dosage:

❑ yes ❑ no Do you or have you ever taken Fosomax, Reclast, Boniva, or Actinol? If yes, please list dates + duration:

❑ yes ❑ no bleeding or clotting disorders

❑ yes ❑ no artificial joint? If yes, location: _____

❑ yes ❑ no high blood pressure

❑ yes ❑ no Diabetes

❑ yes ❑ no Rheumatic fever

❑ yes ❑ no heart murmur

❑ yes ❑ no artificial heart valves

❑ yes ❑ no mitral valve prolapse

❑ yes ❑ no pacemaker? If so, list date of placement: _____

❑ yes ❑ no HIV positive

❑ yes ❑ no Have you been exposed to the HIV virus?

❑ yes ❑ no Hepatitis? If yes, which type? ❑ A ❑ B ❑ C

❑ yes ❑ no Have you ever had Tuberculosis?

❑ yes ❑ no Do you now or have you ever smoked? ❑ cigarettes ❑ pipe ❑ cigar

❑ yes ❑ no Do you chew tobacco/use smokeless tobacco?

❑ yes ❑ no Pregnant? Expected delivery date: _____

❑ yes ❑ no Do you have any disease, condition or problem not previously listed that you feel we should know about? If so, please explain.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A | PATIENT GIVING CONSENT

patient name _____

address _____

city _____ state _____ zip _____

home phone _____ email _____

SECTION B | 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 as in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your 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:

Dr. George T. Ransdell | 2601 Nashville Road | Bowling Green, KY 42101 | 270-842-5229

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person 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. I also understand that by signing this Consent, I am giving you my consent to contact me by home phone, work phone, written communication or to leave a message at home or at work.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____ Relationship to Patient _____

>> YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. <<

REVOCATION

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare 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 continue to treat me after I have revoked my Consent.

Signature _____ Date: _____

FINANCIAL POLICY

Payment is due the day services are rendered unless advanced arrangements have been made. A monthly finance charge of 22% is automatically tabulated to an account that is 90 days or older. Should an account become delinquent, the patient shall assume all additional collection costs and legal fees. A $34 per hour broken appointment fee may be charged to an account for all broken appointments and/or last minute cancellations. 24 hours notice of cancellation is appreciated if you are unable to keep your appointments.

For our patients with dental insurance—

We are happy to assist you in filing the necessary forms to help you receive the full befits of your coverage; however, we can make no guarantee of estimated coverage or payment. Because he insurance policy is an agreement between you and your insurance company, we ask that all patients be directly responsible for all charges. If your insurance company does not assign benefits to our office, payment will be due the day of service unless prior arrangements have been made. Please know that we will do everything possible to see that you receive the full benefits of your policy.

PAYMENT OPTIONS

CASH OR CHECK

We are happy to offer a 5% accounting courtesy for all treatment over $10,000 that is paid in full prior to treatment commencing.

CREDIT OR DEBIT CARDS

We are happy to accept full or partial payment by MasterCard or Visa.

INSURANCE ASSIGNMENT + RELEASE

I hereby authorize my insurance benefits to be directly paid to Dr. George T. Ransdell. I am financially responsible for any balance due. I also authorize Dr. Ransdell to release any information required for this claim. I authorize that my records may be used by Dr. Ransdell if he so determines. In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and financial policy. I certify that I have read, or had read to me, the contents of this form.

I have read the above:

Patient's Signature / Parent or Guardian if a minor _____ Date _____

CONSENT TO TREATMENT

I authorize Dr. George T. Ransdell and staff to take NECESSARY X-RAYS, STUDY MODELS AND OTHER DIAGNOSTIC AIDS as needed to make a thorough diagnosis.

I authorize Dr. Ransdell to PERFORM ALL RECOMMENDED AND AGREED UPON TREATMENT. I also authorize the use of anesthetics, sedatives and other medication [as needed] and am fully aware that using anesthetic agents involves certain risks.

I authorize Dr. Ransdell and staff to USE THE UNIVERSAL PRECAUTIONS as outlined by OSHA and permit the confidential discussion of my medical history. I consent to HIV and Hepatisis blood testing and documentation for needle sticks or injuries resulting during my care.
I have read the above:

Patient's Signature / Parent or Guardian if a minor _____ Date _____

SUBMIT