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PATIENT CONTACT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ SSN: _____ Gender: _____

Home #: _____ Business #: _____ Cell #: _____

E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Height: _____ Weight: _____ Martial Status: ☐ Single ☐ Married ☐ Domestic Partner

Spouse/Partner Name: _____ Occupation: _____ Phone: _____

Guardian's Name: _____ Relation: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: (Not living with you): Name: _____ Relation: _____

Phone: _____ Business #: _____ Cell #: _____

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

Person responsible for payment of this account:

Name: _____ Home #: _____ Business #: _____

Address: _____ City: _____ State: _____ Zip: _____

DENTAL INSURANCE INFORMATION

PRIMARY	SECONDARY
Dental Carrier: _____	Dental Carrier: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone #: _____ Group: _____	Phone #: _____ Group: _____
Insured Name: _____	Insured Name: _____
Relation: _____ Employer: _____	Relation: _____ Employer: _____
Date of Birth: _____ SSN: _____	Date of Birth: _____ SSN: _____

As dental care providers, we want to emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges and payments are your responsibility from the date that services are rendered. We encourage you to read and understand your particular dental policy. By signing below, you authorize Commonwealth Smiles to submit charges to your credit card on file to cover balances due 60 days or more.

Patient / Guardian Signature: _____ Date: _____

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PATIENT HEALTH HISTORY

1. Have you seen a physician in the past 2 years? ☐ Yes ☐ No

If yes, for what reason? _____

Physician name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

2. Are you currently taking any medications? If yes, please list name, dosage & medical condition: ☐ Yes ☐ No

(Additional space available on page four)

_____

3. Have you ever had an allergic reaction to any medications? If yes, please list medication & effects. ☐ Yes ☐ No

_____

Have you ever taken Fenflouramine/Phentermine (FEN-PHEN) medication? ☐ Yes ☐ No

If yes, have you had an echocardiogram? ☐ Yes ☐ No

Date: _____ Results: _____

Are you taking anticoagulant medications? (Coumadin, Warfarin, Plavix, Ticlid, Heparin) ☐ Yes ☐ No

If yes, name of medication? _____ how long taken? _____

Are you taking or have you ever taken bisphosponate drugs? (such as Fosamax, Zometa, Boniva, Actonel, Didronel, Aredia, Skelid) ☐ Yes ☐ No

If yes, medication name? _____ how long taken? _____

4. Women, please answer the following additional questions:

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

5. Do you have or have you ever had any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
Alcohol Use:	☐	☐	Convulsions/Epilepsy:	☐	☐	Heart Murmur:	☐	☐	Mitral Valve Prolapse:	☐	☐
Allergies/Sinusitis:	☐	☐	Diabetes:	☐	☐	Hemophilia:	☐	☐	Pacemaker:	☐	☐
Anemia:	☐	☐	Depression/Anxiety:	☐	☐	Hepatitis (A, B, C):	☐	☐	Psychiatric Care:	☐	☐
Arthritis/Rheumatism:	☐	☐	Dizziness/Fainting:	☐	☐	Herpes:	☐	☐	Rheumatic Fever:	☐	☐
Artificial (Joints, Limbs):	☐	☐	Drug Use (Recreational):	☐	☐	High Blood Pressure:	☐	☐	Snoring/Sleep Apnea:	☐	☐
Asthma:	☐	☐	Emphysema:	☐	☐	HIV/AIDS:	☐	☐	Stroke:	☐	☐
Blood transfusion:	☐	☐	Glaucoma:	☐	☐	Jaundice:	☐	☐	Thyroid (Hypo/Hyper):	☐	☐
Cancer, Tumors:	☐	☐	Headaches, Migraines:	☐	☐	Kidney disease:	☐	☐	Tuberculosis:	☐	☐
Chemo/Radiation:	☐	☐	Heart Attack/Disease:	☐	☐	Latex Sensitivity:	☐	☐	Ulcers:	☐	☐
Chest Pain:	☐	☐	Heart Surgery:	☐	☐	Liver disease:	☐	☐	Venereal disease:	☐	☐

Do you have or have you had any disease, condition or problem not on this list? If yes, please describe: _____

I understand that the information gathered on this medical history form is intended to help inform Commonwealth Smiles of any pre-existing medical conditions so that the best course of treatment can be determined. I understand that failure to disclose this information could affect my own safety. I affirm that the medical information indicated here is accurate and complete.

Patient / Guardian Signature: _____ Date: _____

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DENTAL HISTORY

1. On a scale from 1-10 (10 being best):

	1	2	3	4	5	6	7	8	9	10
a. Where do you rate your dental health now?	○	○	○	○	○	○	○	○	○	○
b. Where would you like your dental health to be in 5 years?	○	○	○	○	○	○	○	○	○	○

2. Are you satisfied with your smile? ☐ Yes ☐ No

3. Have you previously had dental care using any of the following? (Check all that apply)

☐ Nitrous Oxide ☐ Oral Medication ☐ I.V. Sedation ☐ Dental Numbing

Have you ever had an unpleasant experience with any of these? Explain.

_____

4. How can Commonwealth Smiles best serve you and your dental needs?

_____

5. What is the date of your last dental visit? _____ Dental Cleaning? _____ X-rays? _____

6. Have you ever had any unsatisfactory experiences with previous dental treatment or providers? ☐ Yes ☐ No
Please explain.

_____

7. Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No

8. Have you ever had orthodontic therapy or worn braces? ☐ Yes ☐ No

9. Do you clench or grind your teeth? ☐ Yes ☐ No

10. Do you smoke? ☐ No ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless Tobacco

11. Do you have:

	Yes	No		Yes	No		Yes	No
Bleeding, sore gums:	☐	☐	Sensitivity to sweets:	☐	☐	Abnormal Red/White Spots:	☐	☐
Loose teeth:	☐	☐	Sensitivity to biting/chewing:	☐	☐	Shifting of teeth:	☐	☐
Burning tongue/lips:	☐	☐	Unpleasant taste/breath:	☐	☐	Change in bite:	☐	☐
Sensitivity to hot/cold:	☐	☐	Clicking / Locking Jaw:	☐	☐	Food impaction:	☐	☐

12. How often do you: Brush _____ x's/day Floss _____ x's/day or week

13. Do you use a standard or electric toothbrush? ☐ Standard ☐ Electric

14. Do you use a fluoride or plaque rinse? ☐ Yes ☐ No Type/Brand? _____

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Is there anything else you would like to share about your medical history?

Is there anything you would like to share about your past dental experiences?

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FINANCIAL/INSURANCE POLICY

Welcome to Commonwealth Smiles! It is our pleasure to have you as our patient. Our commitment is to provide you with the best possible dental care and to keep you informed of treatment recommendations and financial obligations. The following is our office payment policy:

Payment for Services

Payment is due at the time services are rendered, as Commonwealth Smiles is a fee for service practice. For certain types of treatment, such as procedures involving sedation or anesthesia, payment may be required in advance. We accept cash, Credit Card, Care Credit, money orders, and personal checks.

If you have Insurance

If you have dental insurance, we will be glad to help you receive reimbursement for your allowable benefits. Please keep in mind that your insurance plan is a contract between you, your employer, and the insurance company. The contract is in no way a binding obligation between the Dental Insurance Company and Commonwealth Smiles.

- Payment is due in full at the time services are rendered.
- As a courtesy to you, our patient, we will submit a claim to your insurance carrier on your behalf for your reimbursement. Please present your valid insurance card at the front desk.
- Your insurance carrier will review your claim and make a determination of your payment. They may apply your fees to a deductible, require a co-pay, and/or deny coverage/payment. Some services may not be covered by your plan, or your insurance carrier may pay only a portion of the charges. We cannot know these amounts in advance; therefore, payment is your responsibility.
- Our office does not guarantee that you will receive reimbursement from your insurance company.

  Please contact your insurance company for answers to specific questions regarding your coverage, their payment policies and reimbursement procedures. Also, please call your insurance company to expedite claims if a claim has not been paid within 30 days.

Other Fees

Returned check fee: There is a $30.00 fee if your check is returned to our office unpaid by your financial institution.

Outstanding balances: Outstanding balances over 60 days are subject to collections fees and an interest rate charge of 18% APR.

We hope that by presenting our policies to you, we will avoid any misunderstandings, and therefore, have more time to dedicate to your dental care. If you have any questions regarding the above information, please do not hesitate to ask - we are here to help!

I certify that I have read, understood, and received a copy of the above Financial/Insurance Policy. I understand my financial responsibility for dental treatment.

Name: _____ Date: _____

Patient / Guardian Signature: _____

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CANCELLATION/MISSED APPOINTEMENT POLICY

Thank you for choosing Commonwealth Smiles to treat your dental needs. It is our goal to provide you with the best care possible. When you become a patient of this practice, we commit to your treatment plan and deliver healthy and beautiful smiles in a medically safe and service-oriented setting. To that end, the dentists of Commonwealth Smiles limit their selection of patients to those who are most motivated to begin a sequence of treatment appointments that will end up producing an elegant and predictable result. Because of the specialized nature of our practice and our commitment to excellence, we ask every patient to adhere to our cancellation policy.

We place a high value on our patients, and our front office staff will always try to accommodate your emergencies. However, failure to notify our office of a cancellation means that we cannot offer that time to other patients. For this reason, we ask that you contact our office and speak with an employee of Commonwealth Smiles in order to cancel your appointment.

If you are more than ten minutes late, we reserve the right to reschedule your appointment to another time so that we can keep the schedule intact for the rest of that day's patients.

Late and missed appointments will be documented in patient accounts. Emergencies will be taken into consideration. After two incidents, patients may be dismissed from this practice.

We acknowledge that we occasionally run behind schedule. We apologize, in advance, for these inconveniences, and ask for your understanding that dental emergencies occasionally create delays in our schedule. Please let us know if you have any questions about this policy. We appreciate your cooperation in this matter.

I certify that I have read, understood, and received a copy of the above Cancellation/Missed Appointment Policy. I understand my financial responsibility for dental treatment.

Name: _____ Date: _____

Patient / Guardian Signature: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

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 issue 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:

Contact Person: Jessica Kress, DMD | Telephone: (859) 276-4537

E-mail: info@commonwealthsmiles.com | Address: 1636 Nicholasville Rd. Suite 5, Lexington, KY 40503

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 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 health care operations.

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.
Include completed Consent in the patient's chart.

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

REVOCATION OF CONSENT

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 to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect May 21, 2012 , and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us by using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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NOTICE OF PRIVACY PRACTICES

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.00 for each page, $25 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instance in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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Jessica Kress, D.M.D.
1636 Nicholasville Road, Suite 5, Lexington, KY 40503
www.commonwealthsmiles.com
info@commonwealthsmiles.com
Phone: (859) C-SMILES
Fax: (859) 368-8842

CONFIDENTIAL INFORMATION

Fax: _____

Your Previous Dentist Phone #: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Commonwealth Smiles
Jessica Kress, D.M.D.
1636 Nicholasville Road, Suite 5
Lexington, KY 40503
859-276-4537
info@commonwealthsmiles.com

This request and authorization applies to:
☐ Healthcare information relating to the following treatment, condition, or dates:

_____

X All healthcare information
☐ Other: **Please email all x-rays and notes you have for this patient. If unable to email, please mail. Thanks!**

Please send us a PANO if you have one. Thanks!

Patient or Parent/Guardian Signature _____

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Jessica Kress, D.M.D.
1636 Nicholasville Road, Suite 5, Lexington, KY 40503
www.commonwealthsmiles.com
info@commonwealthsmiles.com
Phone: (859) C-SMILES
Fax: (859) 368-8842

Photography Release

I, _____, hereby authorize Commonwealth Smiles and Dr. Jessica Kress to take photographs, slides, and/or video of my face, jaws and teeth.

I understand that the photographs, slides, and/or videos will be used of a record of my care any may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, and television) and professional publications (dental magazines and journals). These images may include full face portraits and close-up view of teeth.

Furthermore, I understand that if photographs, slides, and/or video are used in any publications or as part of a demonstration my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise for use of these photographs

_____ _____

Signature Date