PATIENT REGISTRATION & INFORMATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION:

Patient Information:

FIRST NAME INITIAL LAST NAME HOME PHONE
ADDRESS CITY STATE ZIP SOCIAL SECURITY
BIRTHDATE AGE EMPLOYER WORK PHONE/EXT CELL PHONE

OCCUPATION BUSINESS ADDRESS CITY STATE ZIP E-MAIL

Spouse Information:

FIRST NAME INITIAL LAST NAME SOCIAL SECURITY
BIRTHDATE AGE EMPLOYER WORK PHONE/EXT

OCCUPATION BUSINESS ADDRESS CITY STATE ZIP

Dental Insurance Information:

PRIMARY INSURANCE COMPANY ADDRESS/CITY/STATE/ZIP

EMPLOYEE SOCIAL SECURITY# MEMBER# GROUP#

SECONDARY INSURANCE COMPANY ADDRESS/CITY/STATE/ZIP

EMPLOYEE SOCIAL SECURITY# MEMBER# GROUP#

WHO MAY WE THANK FOR RECOMMENDING YOU TO OUR OFFICE? _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____
ADDRESS_____
PHONE (home) # _____

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR PRACTICE? YES NO
NAME: _____

1. Are you experiencing pain or discomfort?	Yes	No
2. Are you in good health?	Yes	No
3. Has there been a change in your general health within the past year?	Yes	No
4. Are you under the care of a physician?	Yes	No
If so, what condition is being treated? _____	Yes	No

Physician's Name _____
Address _____

5. Have you been hospitalized or had a serious operation or illness within the last 5 yrs? Yes No

6. Do you have or have you had any of the following diseases or problems? Please Circle

Heart failure	Emphysema	Diabetes
Heart Disease or Attack	Cough	Thyroid Disease
Angina Pectoris	Tuberculosis (TB)	X-ray of Cobalt Treatment
High Blood Pressure	Asthma	Chemotherapy (Cancer, Leukemia)
Heart Murmur	Hay Fever	Arthritis
Rheumatic Fever	Sinus Trouble	Rheumatism
Congenital Heart Lesions	Allergies or Hives	Cortisone Medicine
Scarlet Fever	Artificial joint	Glaucoma
Artificial Heart Valve	Anemia	Pain in Jaw Joints
Heart Pacemaker	Stroke	Fainting or Dizzy Spells
Heart Surgery	Kidney Trouble	Epilepsy or Seizures
AIDS	Ulcers	Cold Sores
Hepatitis A (Infectious)	Bruise easily	STD or VD (Syphilis, Gonorrhea)
Hepatitis B (serum)	Sickle Cell Disease	Blood Transfusion
Liver Disease	Psychiatric Treatment	AIDS Virus
Yellow Jaundice	Nervousness	

7. Are you taking any drug or medicine? Yes No
If so, what _____

8. Are you allergic or have you reacted adversely to any drugs or medicines? Yes No
If so, what _____

9. When you walk up stairs or talk a walk , do you ever have to stop because of pain in your chest? Yes No

10. Do your ankles swell during the day? Yes No

11. Have you had any serious trouble associated with any previous dental treatment? Yes No
If so, please explain:

_____

12. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No

13. Do you have a disease, condition, or problem not listed above that you think I should know? Yes No
If yes, please explain: _____
_____

14. FOR WOMEN ONLY: Are you pregnant? Yes No
If yes, what month? _____ Are you taking birth control pills? Yes No

CONSENT: The undersigned hereby authorizes the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1/5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I(We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

PATIENT _____ DATE _____ Witness _____

PARENT OR RESPONSIBLE PARTY _____
RELATIONSHIP TO PATIENT _____

Dr. Charles B. Barrett

4505 Shelbyville Road Suite 102
Louisville, KY 40207
502.895.0911 502.895.0998

PLEASE HANDLE ME WITH CARE

Do you have any of the following concerns?

☐ I have health problems and questions that we need to discuss.

☐ Pain relief is a top priority for me.

☐ My teeth are very sensitive.

☐ I don't like the color of my teeth.

☐ I don't like the appearance of my teeth when I smile.

☐ I gag easily.

☐ I have not been to the dentist in a long time.

☐ I feel uncomfortable/embarrassed about your thoughts concerning my teeth and dental hygiene.

☐ I don't like shots.

☐ I don't like the way my teeth fit together when I bite.

☐ I don't like the sound of the drill.

☐ Please respect my time. I don't want to be left sitting in the reception area.

☐ I would like to have whiter, brighter teeth.

☐ I want to know the cost up front. No money surprises please.

☐ I don't like the feel of cotton in my mouth.

☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.

☐ Please tell me what I need to know to make an informed decision concerning my treatment.

☐ I want to talk with you about being sedated for my procedures.

How often do you brush your teeth? _____

What kind of toothbrush to you use? (soft/medium/hard) _____

How often do you floss? _____

Any other concerns or comments? _____

_____

_____

_____

INFORMATION FOR PATIENTS WITH DENTAL INSURANCE

If you have dental insurance, we will assist you in every way possible to maximize our dental insurance benefits including filling out and filing the forms at no charge. Of course, it is your responsibility to deal with your insurance company and your employer regarding premiums and coverage. *Please be advised that we are not a participating provider for any insurance company.*

While helping you take maximum advantage of insurance reimbursement, we feel it is our responsibility to make recommendations for what we feel is the best treatment for you without feeling limited to the amount your dental insurance pays.

Here is some information about the dental insurance system that will help to explain why what is best for you may not always be the same as what your insurance will pay:

FACT #1: Dental insurance differs in some ways from regular health insurance that covers physician and hospital costs. Not everyone gets ill but nearly everybody has some dental costs. The amount of money available to pay dental insurance costs is equal to the amount contributed by employees and employers minus costs of operating the insurance company and a normal company profit. So the lower your premiums for the insurance, the less money there is available to pay claims.

FACT #2: To protect themselves, insurance companies usually make up a schedule of what they view as "usual and customary fees." It is our experience in dealing with over 1,000 dental insurance plans that some schedules actually only cover 40 – 50) of customary fees. Others may cover up to 80% with certain deductibles, maximums and exclusions. Rarely does insurance cover 100%.

FACT #3: Since insurance companies are in business to sell insurance and make a profit, it is natural that they may try to shift the blame for their lack of coverage onto the dentist and his fee schedule rather than admitting their coverage is less than customary.

It is very appropriate for you to call your insurance carrier and ask any questions regarding the details of the insurance plan they are operating in your behalf.

We will do our very best to make as close a calculation as possible of what your insurance plan will pay so you will know in advance approximately how much additional you may need to pay over and above what your insurance will cover.

We want you to be comfortable in dealing with these matters and urge you to ask us if you have any questions regarding our services and fees.

- I authorize the release of all necessary information to my insurance company.
- I authorize payment of benefits directly to the provider (if applicable)
- I have read this form and agree to be financially responsible for all fees regardless of insurance coverage.

Signature_____ Date_____

Notice of Privacy Practices Acknowledgement

Barrett Dental Care
4505 Shelbyville Road, Suite 102
Louisville, KY 40207

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments and Physicians certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at ay time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices* acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason