Georgetown
Periodontics
& Implant Dentistry

107 Frazier Ct., Suite 1D, Georgetown KY ¤ (502) 570-5700

THE FOLLOWING INFORMATION IS CONFIDENTIAL.

Patient Name: _____ Sex: _____ Weight: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Address:

Street: _____ City: _____ State: _____ Zip: _____

Telephone:

Home: _____ Cell: _____ Work: _____

E-mail: _____

Employed by: _____ Position: _____

Name of Dentist: _____

Who may we thank for your reference? _____

Why were you referred to the periodontist? _____

Name and address of insurance carrier: _____

Policy Number: _____ Person responsible for account: _____

DOB (if different than self): _____ SSN # (if different than self): _____

Emergency Contact: _____

Preferred Pharmacy: _____

GENERAL HEALTH

Yes No Are you under the regular care of a physician? If so, for what?

_____

Yes No Are you taking any pills, medications, or drugs? If so, please list.

_____

Yes No Have you had any unusual reaction or allergies to any medications or food? If so, please list.

_____

Yes No Are you taking any weight loss medications/shots?

Yes No Do you smoke?

Yes No Have you had abnormal bleeding after a cut or a tooth extraction?

Yes No Are you pregnant?

Yes No Have you taken any medications for osteoporosis or drugs known as bisphosphonates (Fosamax, Boniva, etc.)?

Do you have or have you ever had any of the following (PLEASE CHECK ALL THAT APPLY):

_____ HIV/AIDS
_____ Rheumatic fever
_____ Heart Murmur
_____ Heart Attack
_____ Arteriosclerosis
_____ Diabetes
_____ Stroke
_____ Abnormal thirst
_____ Osteoporosis
_____ X-ray or radiation therapy
_____ Problems in hearing
_____ Frequent headaches
_____ Allergies
_____ Glaucoma
_____ Frequent fractures
_____ Condition requiring cortisone or other steroids
_____ Hepatitis, jaundice, or other liver disease
_____ Shortness of breath or chest pains upon exertion
_____ Tuberculosis, emphysema, or other lung condition
_____ Epilepsy, Seizures, convulsions, or fainting spells
_____ Taken medication for osteoporosis
_____ Cancer/cancer treatment
_____ Alcoholism
_____ Ulcers (stomach or duodenal)
_____ Kidney or bladder trouble
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Thyroid or Parathyroid disease
_____ Asthma or difficulty breathing
_____ Anemia or other blood disorder
_____ Frequent vomiting or diarrhea
_____ Arthritis or rheumatism
_____ Painful or swollen joints
_____ Rashes or skin disorders
_____ Dizziness or light headaches
_____ Sinus problems
_____ Sexually related diseases

CONSENT FOR TREATMENT

I authorize the dentist to perform diagnostic procedures and treatment necessary for proper dental care.

I authorize the release of information concerning my (or my child's) healthcare, advice, and treatment provide for the purpose of evaluating and administering claims for insurance benefits and to another dentist.

I hereby authorize payments of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing the statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental payor.

I attest to the accuracy of the information on this form.

PATIENT'S OR GUARDIAN'S SIGNATURE: _____

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 CAREFULLY AS THIS IS IMPORTANT TO YOU AND US.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations.

TREATMENT: We may use or disclose your health information to a dentist, physician, or other healthcare provider providing you with treatment.

PAYMENT: We may use and disclose your health information to obtain payment for services provided.

YOUR AUTHORIZATION: In addition, you may give us authorization to use health information or to disclose it to anyone for any purpose. This authorization may be revoked at any time. Revocation of authorization will not affect any use or disclosures permitted while it was in effect. Unless given to us in written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. By state law, your authorization is valid for 90 days.

YOUR FRIENDS AND FAMILY: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Information about your health may be disclosed to family, friend, or other person only to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

REQUIRED BY LAW: We may 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 reasonable believe that you are a possible victim of abuse, neglect, domestic violence, or 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 and safety of others.

APPOINTMENT REMINDERS: We may use or disclose health information to provide you with appointment reminders (such as voice 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 must make a request in writing to obtain access to your health information.

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

ALTERNATIVE COMMUNICATION: You have the right to request communication by alternative means or to alternative locations. The request should be completed in writing. Alternatives need to be specified, and provide satisfactory explanation how payments will be handled under the alternative means.

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

ELECTRONIC NOTICE: If you receive this notice on a Web site or by electronic mail, you are entitled to receive this Notice in written form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

PATIENT'S OR GUARDIAN'S SIGNATURE: _____

DATE: _____

*You may refuse to sign this acknowledgement.

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, as required by law, but could not obtained due to:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

FINANCIAL POLICY

Thank you for choosing us for your dental care. We are committed to providing you with the best possible treatment. Your clear understanding of our financial policy is important in providing you with informed care.

REGARDING INSURANCE: Your insurance is a contract between you, your employer and the insurance company. We are not a party to the contract. We cannot guarantee payment or claims. You are responsible for your treatment. The policyholder must handle any disputed claim or non-payment of a claim with the insurance company. We will gladly file your insurance as a courtesy; however, your payment and deductible will be due at time of service.

PAYMENT ARRANGEMENTS: Full payment is expected at time of your treatment. Our office presents you with several different payment options to assist you in paying for your dental treatment. Options are cash, check, or credit card. In the event that a check written to our office were to have insufficient funds there will be a $50 dollar charge in addition to the original amount, or as determined by our legal affiliate. By signing this document you agree that you have read and understand all information regarding financial policy. Acceptance of treatment implies consent to pay all of the cost involved in said treatment. This includes any attorney fees and costs incurred in the collection of delinquent charges.

PATIENT'S OR GUARDIAN'S SIGNATURE: _____

DATE: _____

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PHOTO CONSENT FORM

I hereby give Georgetown Periodontics, and all employees and /or agents of Georgetown Periodontics, the right and permission to use/ and or publish photographs of my teeth for art and promotional purposes including but not limited to, advertising publicity, commercial or display of use. I also, authorize my teeth photos to be posted on social media, such as Facebook, X, Instagram, Tik Toc, and the office website page.

Release of Claims

I hereby release and discharge Georgetown Periodontics and all persons functioning under his/her permissions or authority from any legal or equitable claims including but not limited to the following: blurring of the image(s), alteration, distortion or use in composite form, libel, invasion of privacy or any claims based on the production or in the process of recording or publishing the materials.

Initial the following:

_____ **Yes, you may use my teeth photos.**

_____ **No, you may not use my teeth photos.**

_____ _____

(Please Print) Name of Patient or Parent/Guardian **Date**

_____ _____

Signature of Patient or Parent/Guardian **Date**