Ryan P. Estes, D.M.D **Allison K. Marlow, D.D.S.**

8136 Mall Road, Florence, KY 41042 ryanestesdmd@gmail.com

(859) 371-6543

Welcome to our Practice

Patient First Name:_______________________________ Last:_____________________________ MI:_____

Gender: ◯ Male ◯ Female Birth Date:________________ SS#:_____________________

Address: ____ APT/ Suite:________________

____

Phone:

Mobile:____________________________ Home:_______________________ Work:___________________

Email Address:____

Emergency Contact: (Name, Relation, Phone)

____

Employer Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both

Employer Name:______________________________________ Phone:_______________________________

Address:____

Primary Dental Insurance

Name of Subscriber:_______________________________ DOB:_______________ SS#:_________________

Subscriber Address:____

Relationship to patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Subscriber Employee Name:____

Insurance Plan Name:____ ID#___________________________

Insurance Provider Phone Number:_____________________________ Group/ Client #:________________

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Secondary Dental Insurance

Name of Subscriber:______________________________ DOB:______________ SS#:________________

Subscriber Address:____

Relationship to patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Subscriber Employee Name:____

Insurance Plan Name:____ ID#__________________________

Insurance Provider Phone Number:____________________________ Group/ Client #:_______________

Insurance Authorization:

□ By checking this box, I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understands that I am financially responsible for all charges, whether or not paid by insurance.

Medicare Opt-Out Private Contract

Dentist represents that we are excluded from participation under the Medicare Program both patient and dentist acknowledge that patient is not experiencing an emergency health situation.

Patient Acknowledges: Not to submit a Medicare claim or request Dentist to submit a claim even if they are covered under Medicare for any services provided.

Patient is fully responsible for payment of services and no reimbursement will be provided under Medicare for the services. The patient will be responsible for payment of services at the Dentists' usual rate and regular payment agreements. Medigap and other supplemental insurance plans do not or may not elect to cover services as payment is not made under Medicare. Patient has right to have other providers provide services. Patient is not required or compelled to enter into private contracts that apply to other Medicare covered services furnished by other dentist who have not opted out. Patient agrees to reimburse Dentist for any costs and reasonable attorneys' fees that result from violation of the Agreement by patient and his/her beneficiaries.

Contract is in effect from date of signature until end of Dentist's end of opt out period.

Signature____ Date:_________________________

Consent for Services and Financial Policy

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As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred for their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

◯ By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.

HIPPA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

◯ By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.

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Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Dentist name and how long you have been a patient there:

____

____

Date of most recent dental visit _____________

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern/ How did your dentist explain why you are seeing us?

____

____

____

____

____

____

____

____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) ______________

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted
☐ Had any teeth removed

Notes:

____

____

Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?
☐ Have you ever whitened (bleached) your teeth?
☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ Have you been disappointed with the appearance of previous dental work?

Notes:

____

____

Bite and Jaw Joint, Check all that apply:

- [ ] You have problems with your jaw joint
- [ ] You have any problems chewing
- [ ] Your teeth changed in the last 5 years, become shorter, thinner, or worn
- [ ] Your teeth crowding or developing spaces
- [ ] You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- [ ] You clench you teeth in the daytime or make them sore
- [ ] You have problems with sleep or wake up with an awareness of your teeth
- [ ] You wear or have worn a bite appliance

Notes:

____

____

Tooth structure, Check all that apply:

- [ ] Cavities within past 3 years
- [ ] The amount of saliva in your mouth seems too little or you have difficulty swallowing food
- [ ] Any teeth sensitive to hot, cold, biting, sweets, or you avoid brushing any part of your mouth
- [ ] Any teeth with grooves, notches, chips, a cracked filling or pain
- [ ] Food gets caught between any teeth

Notes:

____

____

Gum and Bone, Check all that apply:

- [ ] Gums bleed when brushing or flossing
- [ ] Treated for bone loss
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] History of periodontal disease in your family
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- [ ] Experienced a burning sensation in your mouth

Notes:

____

____

If any of the checked boxes need further explanation, please describe:

____

____

____

____

____

____

____

Response Date: ____/____/________

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Medical History

Patient Name: ________________ * ________________ * ____ ________________
Last | First | MI | Preferred Name

Do you smoke or use tobacoo? * ◯ Yes ◯ No

How many years have you smoked or used tobacco? ____________

How many packs a day do you smoke? ____________

Have you ever smoked or used tobacco? * ◯ Yes ◯ No

When did you quit? ________________

Female: Do you take Birth Control Pills? ◯ Yes ◯ No

Female: Are you pregnant? ◯ Yes ◯ No

Female: Are you nursing? ◯ Yes ◯ No

Have you in the past or currently taken medication for osteoporosis, osteopenia, bone cancer, or post-meopausal Bone Loss? *
◯ Yes ◯ No

If yes, what medication was taken and how long?

____
____

Are you allergic to any medications? Please note type of reaction. (example: Rash)
Example: Penicillin, Codeine, Aspirin, Metals, Latex, etc.

____
____
____
____

Please list all medications and amounts you are taking including vitamins, supplements, and herbs.

____
____
____
____
____
____
____

Please check all that apply to you:

Heart:

☐ High Blood Pressure ☐ Heart Disease ☐ Heart Murmur ☐ Pacemaker ☐ High Cholesterol

Notes:

Lungs:

☐ Asthma ☐ COPD/Ephysema ☐ Sleep Apnea ☐ Respiratory Problems ☐ Sinus Problems

Notes:

Brain & Nerves:

☐ Dizzines ☐ Fainting ☐ Epilepsy ☐ Stroke/TIA ☐ Head Injuries ☐ Nervous Disorders
☐ Alzheimers/Dementia ☐ Glaucoma

Notes:

Blood:

☐ Anemia ☐ Excessive bleeding ☐ Blood Diseases

Notes:

Endocrine:

☐ Diabetes ☐ Thyroid Disease

Notes:

Kidney Disease:

☐ Kidney Disease

Notes:

Stomach & Intestines:

☐ Liver Disease ☐ Hepatitis ☐ Jaundice ☐ Stomach Disorders ☐ Ulcers ☐ GERD/Acid Reflux

Notes:

Muscle & Skeleton:

☐ Arthritis ☐ Rheumatic Arthritis ☐ Rheumatic Fever ☐ Artificial Joints

Notes:

Psychiatric Disease:

☐ Depression ☐ Anxiety ☐ Other Mental Disorders

Notes:

Cancer:

☐ Cancer ☐ Benign Tumors ☐ Chemotherapy ☐ Radiation Treatment

Notes:

Skin/Connective Tissue:

☐ Skin disorders

Notes:

Infectious Diseases:

☐ HIV/AIDS ☐ Tuberculosis ☐ Cold Sores/Herpes ☐ Venereal Diseases

Notes:

Are you under a physicians care? * ◯ Yes ◯ No

If yes, please list name and contact information.

____

____

Have you ever been hospitalized or had a major operation? * ◯ Yes ◯ No

If yes, please explain:

____

____

Is there any additional medical information you need to provide or disease, condition, or problem that was not covered above?

____

____

____

____

____

____

☐ ***To the best of my knowledge, I have answered every question completely and accurately. I understand that this information wil be held in strict confidence and it is my responsibility to inform this office of any changes in my medical status.**

Response Date: ____/____/________