C. Brandt Brooks, D.M.D.
436 Main Street, Paris, Kentucky 40361
(859) 987-5550

Patient Name _____ **Date of Birth** _____

Thank you for choosing us for your dental health needs. We are committed to providing you the best possible treatment. Your clear understanding of our financial policy is important in providing you with the most 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. It is very important that you understand the provision of the policy. We cannot guarantee payment or claims. No matter what your insurance pays, you are responsible for the full amount of your treatment. Any disputed payment or nonpayment of claim must be handled by the policyholder, not our office. We will gladly file your insurance as a courtesy; however, your copayment and deductible will be due at the time that service is provided. Any claim that is not paid within 30 days becomes the full responsibility of the patient.

All Patients:

Your appointment is a reservation of time specifically for you and the doctor/hygienist. It is our goal to ensure that our patients have access to care and that our patients wanting care have access to all available appointments. Therefore, it is expected of you to keep your reservation once it has been made or that you will provide **more than a 24-hour notice** if you cannot make the reservation. If you fail to give the required 24-hour advanced notice or if you fail to show for a confirmed appointment, there will be a **$50.00 missed appointment fee** charged to your account that must be paid before the appointment may be rescheduled. This fee will be charged for each subsequent missed appointment without 24-hour notice.

Full payment is expected at the time of your treatment. Our office presents you with several different options to assist you in paying for your dental treatment. Methods of payments are:

Cash, Check (post-dated checks are acceptable under $200.00), and Credit Cards. We accept MasterCard, VISA, American Express, and Discover.

We also offer a monthly payment options:
Membership Plan - we offer a membership plan to our patients without insurance. This plan can be paid yearly or monthly and offers reduced fee on services. Please ask our team for more details.

Lending Club - Third-party lending option. Please ask for details.

CareCredit - Third-party lending option. Please ask for details.

By signing this document, you agree that you read and understand all information regarding this financial policy. Acceptance of treatment implies my consent to pay all of the involved costs of said treatment. This includes any attorney fees and costs incurred in the collection of the account, should it become delinquent. Accounts 60 days past due will be subject to a 1.5% monthly interest charge.

_____ _____

SIGNATURE (Parent/Guardian if patient is a minor) **DATE**

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that Personal Healthcare Information (PHI) is protected for privacy. The Privacy Rule was also created to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment, or healthcare operations in order to provide dental care that is in your best interest.

We want you to know that all of our employees and doctors undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships on your behalf (such as laboratories that only interact with dental offices), and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

You have the right to give permission to our office to release information to the following concerning your dental care. This includes appointment time, medications, test/lab results, and treatment:

_____ Spouse Name _____

_____ Other Specified Person Name _____

_____ Other Specified Person Name _____

We also want you to know that it is our policy to produce postcards notifying you of upcoming appointments and to leave messages on answering machines notifying you of upcoming appointments.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your PHI. If you choose to give consent in this document, at some future time, you may request to refuse to disclose all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

You have the right to review our privacy notice, to request restrictions, and revoke this consent in writing after you have reviewed our privacy notice. If you have any questions about this form, please ask to speak with our HIPAA Compliance Officer.

_____ _____

SIGNATURE (Parent/Guardian if patient is a minor) **DATE**

OFFICE USE ONLY

I attempted to have patient sign form on _____, but patient refused.

DATE

PATIENT INFORMATION

Patient Name _____ Date of Birth _____
Home Address _____ City _____ State ____ Zip _____
Phone Number (Home) _____ (Business) _____ (Cell) _____
Email Address _____ SSN ____-____-____
Marital Status (Please Circle) Single Married Divorced Widowed
Spouse's Name _____
Who should be notified in case of an emergency? (Name and Phone Number)

_____

Someone NOT living with you who would know how to reach you: (Name and Phone Number)

_____

How did you hear about our office? _____
Reason for your visit: _____

BILLING INFORMATION

Person responsible for bill: _____
If other than patient, please fill out below:
Address _____ City _____ Zip _____
Phone Number (Home) _____ (Business) _____ (Cell) _____
Date of Birth _____ SSN _____-____-_____

_____ _____

SIGNATURE (Parent/Guardian if patient is a minor) **DATE**

Please read below and sign. Complete back of form.

INSURANCE INFORMATION

Policyholder's Name (IF not patient or billing party) _____
Policyholder's Address _____ Phone _____
Policyholder's SSN ____-____-___ Date of Birth _____
Employer _____ Employer Phone Number _____
Insurance Company (Primary):_____ (Secondary): _____

Please read and sign below, then complete back of form.

We file your insurance as a courtesy and accept payment directly from the insurance company. HOWEVER, most insurance plans are NOT designed to pay for your services in full. Any balance not covered by insurance will be estimated and collected from at the time service is provided. Should there be any balance left after we receive insurance payment, you will be billed for this balance.

I authorize the release of information relating to dental claims. I understand that I am responsible for all costs of dental treatment, including those costs not covered by my insurance. I also authorize payment of any insurance benefits to the named dentist.

_____ _____

SIGNATURE (Parent/Guardian if patient is a minor) **DATE**

HEALTH INFORMATION

General Health (Please Circle): Excellent Good Fair Poor

Physician Name _____ Phone _____

Are you currently under the care of a physician? (Please Circle) YES NO

If so, for what reason? _____

Are you currently taking any medications? (Please Circle) YES NO

If yes, please list all medications: _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____

Do you use cocaine? (Please Circle) YES NO (Please be advised that Novocain can be **LETHAL** when mixed with cocaine.)

If you have ever been hospitalized, give reasons and dates: _____

_____

Do you use alcohol? (Please Circle) Y N How often? Daily/Weekly/Monthly

Do you smoke? (Please Circle) Y N How many per day? _____

WOMEN: Are you pregnant? (Please Circle) Y N How far along? _____

Do you or have you ever been informed that you have any of the following (circle all that apply):

Heart Problems	Cancer	Asthma	Thyroid Problems
Anemia/Blood Disease	Stroke	Sickle Cell Disease	Hay Fever/Allergies
Epilepsy/Seizures	Ulcers or Colitis	Mitral Valve Prolapse	Unexplained Weight Loss
Arthritis/Rheumatism	Diabetes	AIDS/HIV	Cough/Spit Blood
High Blood Pressure	Radiation Therapy	Respiratory Disease	Dry Mouth
Hemophilia	Heart Murmur	Glaucoma	Bluish Reddish Lesions
Cortisone Therapy	Kidney Problem	Artificial Valve/Joint	Chemical Dependency
Excessive urination or thirst	Tuberculosis	Herpes	Blood Transfusion
Circulatory Problems	Chemotherapy	Sinus Problems	Night Sweats
Excessive Bleeding	Rheumatic Fever	Fainting/Dizzy Spells	Positive TB Test
Psychiatric Care	Liver Disease	Hepatitis/Jaundice	Narcotic Abuse

DENTAL HEALTH (circle all that apply):

Bleeding Gums	Mouth Breathing	Unusual Sounds in Ear When Chewing
Bad Breath	Gag Easily	Pain in or Around Ear
Unpleasant Taste	Swelling/Lumps in Mouth	Complications from Extractions
Periodontal Treatment	Blisters/Sores on Lips or Mouth	Wear Partials or Dentures
Orthodontic Treatment	Clenching/Grinding of Teeth	

What is most important to you in your dental treatment? _____

Do you Snore or have been diagnosed with Sleep Apnea? Y N

How long do you want to keep your teeth? _____ Are you pleased with your smile? Y N

Last Dental Visit: _____ Last X-Rays: _____

How often do you brush? _____ Floss? Y N Do you use a mouth rinse? (Please Circle) Y N

Are your teeth sensitive to (Please Circle): HOT COLD SWEETS CHEWING

Are you nervous about your dental treatment? (Please Circle) Y N

Have you ever had (Please Circle): Nitrous Oxide Medication Prior to Treatment

PLEASE READ BELOW AND SIGN:

I have reviewed the information provided on this form and assert that it is accurate to the best of my knowledge. I understand that prior to treatment a full explanation of the procedure(s) and cost(s) involved will be presented by the doctor and/or staff. I understand that I will have the right to authorize each phase of treatment including the use of any x-rays, models, medications, and/or the use of local anesthetic agents.

_____ _____

SIGNATURE (Parent/Guardian if patient is a minor) **DATE**