Western Kentucky Dental

Chris Pitcock, DMD
1355 Veterans Memorial Blvd., Suite 100
Bowling Green, KY 42101
(270) 846-9994

Patient Information

Patient Name_____ Date_____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy

OTHER:

- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Please list any medications: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Primary Subscriber for Insurance

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such 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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed 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, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

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ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I _____, have reviewed a copy of this office's Notice of privacy Practices. **(HIPAA STATEMENT)**

_____

Please PRINT Name

_____

Signature

_____

Date

For Office Use Only

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

- ❖ Individual refused to sign
- ❖ Communication barriers prohibited obtaining the Acknowledgement
- ❖ An emergency situation prevented us from obtaining acknowledgement
- ❖ Other…as specified below

_____

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FINANCIAL POLICY
Our mission is to provide you with a family like atmosphere in an up-to-date facility where you can be certain that you are given the very best care for your dental needs. In addition, we recognize the need for a clear understanding of your financial obligations for the treatment you receive. In order to create a better understanding between patients and our office, we have adopted the following policy. If you have any questions about this policy, we encourage you to contact our patient accounts department.

PATIENTS WITHOUT INSURANCE COVERAGE:
Unless prior arrangements are made with our patient accounts department, **payment in full is due on the day of service.** For your convenience we accept: cash, check, Visa, MasterCard, and CareCredit. For dental procedures over $200.00, a 10% discount will be given if the patient's balance is paid in full on the day of service; except when using CareCredit. A discount cannot be given for any implant procedures.

PATIENTS WITH INSURANCE COVERAGE:
We participate with numerous insurance plans and will gladly file your claim for you. This is a service provided by the office. Benefits will be assigned to us and insurance payments will be made directly to the office. We will attempt to collect payment from the insurance company for 90 days. If payment is not received in that amount of time, the patient will be held responsible for payment. We will gladly continue to assist you in recovering payment from the insurance company. **Deductibles and co-payments are due the day of service.** Ultimately, the patient is responsible for the balance in full if payment is not received from the insurance company.

RETURNED CHECKS:
Returned checks will incur a $25.00 service fee.

COLLECTION:
The undersigned understands and agrees that the account balance is due, in full, upon receipt of the statement. If the account is not paid in full within 90 days from the date of service, the undersigned agrees to be liable for all costs of collection, including attorney's fees and court costs.

CARECREDIT:
Because your smile is important to us, we offer CareCredit, a healthcare credit card specifically designed to pay for treatments and procedures not covered by insurance. Ask us more about CareCredit today and how you may receive up to 12 months with 0% interest.

MISSED APPOINTMENT FEE:
As a courtesy to our office, we ask our patients to give a 24-48 hour notice if the scheduled appointment must be broken. However, if no notice is given, a missed appointment fee of $50.00 will be charged to the patient's billing statement.

SIGNATURE: _____ **DATE:** _____