ADVANCED
DENTAL SOLUTIONS

General Treatment Consent

Patient Name _____

I give my consent that I (or my above named dependent) receive dental treatment, education, and other dental-related services. I authorize the administration of anesthetics, as may be considered necessary, and the use of oral x-rays during the treatment. I will receive instructions about the benefits and risks of the necessary procedures, and I will have the opportunity to discuss and approve the recommended treatment. I acknowledge that I have not received guarantees, warranties, or representations concerning the results of the treatment or procedures.

I accept the responsibility to follow (or to help my above named dependent follow) oral hygiene and post-op instructions, come to all the appointments on the proper day and time, provide accurate and updated health information, and alert this office of anything that may adversely affect the treatment.

By consenting to treatment, I understand there is risk of infectious diseases. Despite taking reasonable precautions to ensure your health and safety, it is impossible to eliminate all risk of contracting an infectious disease while receiving dental care.

I have the right to withdraw this consent at any time. I will still be responsible for the unpaid balance and for any complication arising from the treatment interruption.

Signature (Patient or Guardian)_____Date _____

I refuse or withdraw my consent for treatment.

Signature (Patient or Guardian)_____Date _____

Summary of Notice of Privacy Practices
Our Privacy Practices comply with Omnibus 2013

Our practice keeps information of all your dental visits. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with your information upon request. You can also find the Notice on our website. This notice is a detailed explanation on how we may use your protected health information and your rights to inspect and amend your information. Law requires us, and by our code of ethics, to keep your information private, and to follow the practices outlined in this Notice. Our Privacy Practices comply with Omnibus 2013 and are updated effective 09/23/2013.

I have had full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.

Print Name: _____ Signature _____ Date _____

For Office Use Only
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but could not obtain acknowledgment because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify)
  _____

ADVANCED DENTAL SOLUTIONS

134 Evergreen Road, Suite 201
Middletown, KY 40243
502-200-5325 | adslouisville.com

Patient Financial Agreement

Patient Name _____ Date _____

Thank you for allowing us the opportunity to care for your dental needs. We are excited to partner with you to improve and maintain your oral health.

For your convenience you can pay for your treatment with cash, check, credit card, or through a third party financing who partners with us, to ensure all patients receive the care they need. We will collect the payment of your treatment at the time of service.

If you would like to use your dental insurance, we will gladly file the insurance claims on your behalf for the portion you expect your insurance to pay. We will also post to your account any insurance payment and adjustments we may receive. We will let you know if your insurance covers only part of the claim, that you may send us the payment for the balance.

If you have the need to change any financial arrangements for any reason, please let us know that we may work with you. In the event, any portion of balance remains unpaid longer than 30 days we will initiate a collection process, which may include collection and financing fees.

Agreement:
By signing below, I confirm that I understand this financial process, and agree with every step. I also state that I am responsible for the cost of my treatment and any third party financing or insurance carrier unpaid balance. I understand and agree that this dental office shares my personal health information for collection purposes only. This agreement does not authorize the dental office to share my information for any other purpose. I understand the dental office may initiate a collection process if any cost for my treatment remains unpaid longer than 30 days.

Patient, Parent (or Guardian) signature: _____Date: _____

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Last Name:_____ First Name: _____Preferred Name:_____

Middle: _____ Title: ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss Home Phone: _____

Address: _____ Work:_____

City _____ST_____ ZIP _____ Cell: _____

Male / Female Social Security: _____ DOB:_____

Referring Dentist or Patient:_____ Dentist Phone: _____

General Physician: _____ Phys. Phone: _____

Patient E-Mail Address: _____

Emergency Contact:_____ Phone _____

Allergies:
- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Jewelry
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Tetracycline
- ❑ Sulfa

Check any of the following that you are taking or have taken:

- ❑ Cortisone Drugs
- ❑ Tranquilizers
- ❑ Steroids
- ❑ Sedatives
- ❑ Anticoagulants
- ❑ Bisphosphinates
- ❑ Blood Thinners

List medications and dosage you are currently taking:

_____
_____
_____
_____
_____

Have you taken Bisphosphonates?
❑ YES ❑ NO
If yes, when?_____

- ❑ Abnormal Bleeding
- ❑ Acid Reflux
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Joint Replacement
- ❑ Asthma
- ❑ Barbiturates
- ❑ Bleeding Disorders
- ❑ Blood Transfusion
- ❑ Cancer / Tumor Chemotherapy
- ❑ Chemical Dependency
- ❑ Depression / Nervousness
- ❑ Diabetes Type 1 or 2
- ❑ Difficulty Breathing

- ❑ Difficulty Swallowing
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fever Blisters
- ❑ Glaucoma
- ❑ HIV Positive or Aids
- ❑ Hay Fever
- ❑ Heart Disease
- ❑ Hepatitis or Jaundice
- ❑ High Blood Pressure ( ) Low BP
- ❑ Iodine Allergy
- ❑ Kidney / Bladder Trouble
- ❑ Neuralgia
- ❑ Pacemaker
- ❑ Psychiatric Problems

- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Shingles
- ❑ Shortness of Breath
- ❑ Sinus Trouble
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Do you have any other conditions or problems not covered above?
❑ Yes ❑ No If yes, describe:
_____
_____

Do you Smoke? ❑ Yes ❑ No Premedication requirement? (Artificial joint replacement) ❑ Yes ❑ No

Current Dentist: _____ Previous Dentist: _____

Last Dental Visit _____ Last Dental X-Rays: _____

What is the presenting problem?_____

What is the history of the problem?_____

What is your desired outcome?_____

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____