Patient Name: _____ Account # _____ Date: _____

PARKWAY
FAMILY DENTAL

New Patient Information

Patient Information

Prefix: _____ First Name: _____ Middle Name: _____ Last Name: _____

Suffix: _____

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

Preferred Phone #: _____ Is this a mobile number? Yes ☐ No ☐

Email Address: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Another Identity _____ ☐ Prefer not to answer

Emergency Contact: _____ Emergency Phone #: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Preferred pronouns _____ Social Security Number _____

Responsible Party

First Name: _____ Middle Name: _____ Last Name: _____

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

Date of Birth: _____ Sex: ☐ Female ☐ Male ☐ Unspecified

Responsible Party Signature: _____ Date: _____

Patient Signatures

Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance)

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Continued on next page →

Please know we take the utmost care in your **private and confidential** information. If you have any questions or concerns please don't hesitate to ask.

MONALI HALDANKAR, DMD - J. TAYLOR HAZARD, DMD
4701 SOUTHERN PKWY, LOUISVILLE, KY 40214 - (502)366-4121
SMILE@PKWYFAMILYDENTAL.COM - PKWYFAMILYDENTAL.COM

Account # _____

PARKWAY
FAMILY DENTAL

Payment, Insurance and Financial Arrangement Policies (signed by ALL new patients)

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Notice of Privacy Practices (must be signed by ALL new patients)

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Authorization for Release of Health Records to External Parties (Optional)

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____

Relationship to the Patient: _____

I give authorization to disclose the following information:

☐ all treatment information

☐ information specifically related to these treatment dates

Starting Date: _____ End Date: _____

Consent to obtain patient medication history (Optional)

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

Signature: _____ Date: _____

Continued on next page →

Account # _____

PARKWAY
FAMILY DENTAL

Consent Form

1. I authorize staff at Parkway Family Dental to take necessary radiographs (x-rays), study modes, photos, scans, and other diagnostic aids as needed to make a thorough diagnosis.
2. I authorize staff at Parkway Family Dental to perform all treatment which has been recommended and agreed upon. In addition, I authorize the use of anesthetics, sedatives, and other medications (as needed) and I am full aware that using anesthetic agents involves certain inherent risks.
3. I authorize staff at Parkway Family Dental to use the **Universal Precautions**, as outlined by OSHA, and permit the confidential discussion of my medical history. I consent to HIV and Hepatitis blood testing and documentation for needle sticks and injuries resulting during my care
4. I am responsible for payment for **ALL** services rendered, on my behalf, and my dependants. I have been informed that payment is due when services are **rendered**. I am aware that a finance charge may result if my account becomes 30 days past due or older. Should my account become delinquent, I will assume all collection costs and legal fees.

Signature: _____ Date: _____

Account # _____

PARKWAY FAMILY DENTAL

Health History

Reason for Visit: ☐ Broken Tooth ☐ Check-up ☐ Cosmetic ☐ Dentures ☐ Tooth Pain ☐ Other: _____
Height: _____ ft _____ in Weight: _____ Patient Date of Birth: _____

Dental History

Date of Last Dental Visit:
☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Date of Last Dental X-ray:
☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Oral Health

Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No
Have you ever had Novocaine or other local anesthetic? ☐ Yes ☐ No
How happy are you with your smile (1-10)? _____
Are you currently wearing Dentures? ☐ Yes ☐ No
Age of dentures: ☐ Less Than 6 Months ☐ 6 months-3 years ☐ Greater than 4 years
Please check any conditions that apply to you below:
☐ Pain In Jaw(TMJ) ☐ Teeth Grinding/Clenching ☐ Use Tobacco Products ☐ Mouth Sores
☐ Sensitive Teeth ☐ Broken/Loose Teeth ☐ Difficulty Chewing/Swallowing ☐ Swollen/Bleeding Gums
Are you under the care of a primary physician? ☐ Yes ☐ No
Primary Physician's Name: _____ Physician's Phone Number: _____
Date of Last Physical:
☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____
Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No
Have you ever been hospitalized? ☐ Yes ☐ No
Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)?
☐ No ☐ Yes How Long? _____
Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No
Are you allergic or have you had an adverse reaction to any of the following?
☐ **None** ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Latex ☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline
☐ Other: _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:
☐ **None**

Account # _____

PARKWAY FAMILY DENTAL

Check any conditions that apply to you:

- ☐ None
- ☐ Alcoholism
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint/Pins
  - Type:_____
  - Age:_____
- ☐ Aspirin Therapy
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Cancer
  - Type:_____
- ☐ Chemotherapy
- ☐ Coumadin Therapy
- ☐ Dementia
- ☐ Diabetes
  - Type:_____
- ☐ Dialysis
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Hearing Impairment
- ☐ Heart Murmur
- ☐ Heart Surgery
  - Date: _____
- ☐ Heart Trouble
  - Type:_____
- ☐ Hepatitis
  - Type:_____
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease/COPD
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Mobility Impairment
- ☐ NON-DENTAL Implants
  - Type:_____
- ☐ Organ Transplants
  - Type:_____
- ☐ Pace Maker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Radiosurgery
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis(TB)
- ☐ Ulcers
- ☐ Visual Impairment
- ☐ Other Disease/Illness
  - Type: _____
  _____

Women Patients Only

Are you currently pregnant? ☐ Yes ☐ No Estimated Delivery Date: _____

Are you Nursing? ☐ Yes ☐ No Are you taking any birth control prescriptions? ☐ Yes ☐ No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I affirm that I have filled this medical history thoroughly to the best of my knowledge:

X _____ Date: _____

Signature