O'Donnell Family Dentistry
1081 Dove Run Road Ste #105
Lexington, KY 40502

Patient Information

Patient Name: _____ Date: _____
Last, First, MI (preferred name)

Address: _____
City State Zip code

SS #: _____ Birth Date: _____ Gender: _____ □ Sing. □ Mar. □ Child □ Other

Home Phone: (_____)_____ Work Phone: (_____)_____ ext: _____

Pager: (_____)_____ Cell Phone: (_____)_____

E-mail Address: _____ Preferred way of contact for appointments: _____

In case of an emergency, who may we contact: _____ Phone # (____)_____
Who may we thank for referring you? _____

Health Information

Date of last dental visit: _____ Reason for this visit: _____

Have you ever had any of the following: (check all that apply)

□ HIV/Aids
□ Allergies _____
□ Anemia
□ Arthritis
□ Asthma
□ Heart Disease
□ Cancer
□ Diabetes
□ Dizziness
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Growths
□ Hay Fever
□ Head Injuries
□ Joint Replacement
□ Heart Murmur
*Meds needed before visits? _____
□ Hepatitis
□ High Blood Pressure
□ Kidney Disease
□ Liver Disease
□ Mental Disorders
□ Pacemaker
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Sinus Problems
□ Stomach Problems
□ Stroke
□ Tuberculosis
□ Other
_____
_____
_____

Are you currently pregnant: _____ If so, due date? _____ Doctors Name: _____

List of medications you are currently taking: _____

Have you ever had complications following dental treatment? If so, please explain: _____

_____

Have you been admitted to the hospital or needed emergency care in the past two years? _____

Are you now under the care of a physician? If so, why: _____

If you could change anything about your smile, what would it be? _____

If I ever have any changes in my health, I will inform the doctor without fail. _____
Signature of patient, parent, or guardian

Responsible Party Information

Whose employer is your dental insurance through? □ Yourself □ Mother □ Father □ Spouse □ Other

If the insurance is not through YOUR employer, please fill out the following for the responsible party:

Name: _____ Date of Birth: _____
Last First MI

Social Security # _____ Home # (_____)_____ Work # (_____)_____

Home Address: _____
City State Zip

Responsible Party's Employer _____ Phone # (_____)_____

Your Employment Information

Employer Name: _____ Occupation: _____

Approximately how long have you been employed there? _____

Insurance Information

Insurance Company Name: _____ Phone # (_____)_____

Group # _____ ID # _____ Approximately how long have you had this insurance? _____

Secondary Insurance Name: _____ Phone # (_____)_____

Group # _____ ID # _____Approximately how long have you had this insurance? _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. This 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 at the time services are rendered. 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 1.5% 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 estimated 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 the 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 written, 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 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 who is responsible for payment