DENTAL CENTER OF FLORENCE, KY, PSC
8076 U.S. HWY 42
Florence, KY 41042

DCOF
Dental Center of Florence

www.DCOF.com
859-282-9741
fax 859-282-2171

Patient Information

Name _____
Birth Date _____
Drivers License # _____
Street Address _____
City _____
State _____
ZIP _____
Home Phone _____
Cell Phone _____
email _____
☐ Male ☐ Female
☐ Child ☐ Single ☐ Married
Person to Contact in Emergency _____
Phone _____

Social Security # _____
Employer _____
Work Phone _____
Employer Address _____
City _____
State _____ ZIP _____
Spouse or Parent's Name _____
Date of Birth _____
If Student, name of school _____
Who referred you to DCOF?
☐ Event ☐ Location ☐ Web Site
☐ Commercial ☐ Radio ☐ Tank Bus
☐ Family/Friend _____
☐ Other _____

Responsible Party

Name of Person Responsible for this Account _____
Relationship to patient _____
Address _____
City _____
State _____
ZIP _____

Home Phone _____
Cell Phone _____
Driver's License # _____
Employer _____
Work Phone _____
Is this Person Currently a Patient of DCOF?
☐ Yes ☐ No

Insurance Information

Name of Insured _____
Relationship to Patient _____
Date of Birth _____
Social Security # _____
Employer Name _____
Insurance Company _____
Group # _____
Insurance Phone # _____

Additional Insurance? ☐ Yes ☐ No
Name of Insured _____
Relationship to Patient _____
Date of Birth _____
Social Security # _____
Employer Name _____
Insurance Company _____
Group # _____
Insurance Phone # _____

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Past Medical History

List all MEDICATIONS (include over-the-counter)
☐ **No medications**

Physician Name:

Physician Phone:

Date of last exam:

	Y	N	details
Do you drink alcohol?			
Do you use tobacco?			
Do you have a history of substance abuse?			
Are you under medical treatment now?			
Have you ever been hospitalized for any surgical operation or serious illness?			
Are you pregnant or think you may be pregnant?			
Are you nursing?			
Are you taking birth control pills?			

History of?	Y	N	details
Heart Valve Surgery			
Bleeding Disorder			
Blood Thinners			
Joint Replacement			
Heart Murmur			
Leukemia			
Diabetes			
Kidney Disease			
HIV			
AIDS			
Hepatitis			
Anemia			
Thyroid disorder			

	Y	N	details
Asthma			
COPD			
Emphysema			
Stroke			
High Blood Pressure			
Heart Disease/Pacemaker			
Low Blood Pressure			
Radiation / Chemotherapy			
Oral / Head / Neck cancer			
Ulcers/GERD			
Cancer			
Liver Disease			
Seizures			
Fainting			

List any other conditions / details / explanations :

ALLERGIC TO ?	Y	N
Penicillin		
Sulfa		
Latex		
Codeine		
Lidocaine		

List all ALLERGIES:
☐ **No allergies**

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or guardian if minor

Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights were given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other health care providers involved in my treatment);
- Obtaining payment from third party payors (e.g., my insurance company);
- The day-to-day operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

X_____ X_____

Signature of patient or guardian if minor **Date**