Sparkle and Shine Family Dental

PATIENT INFORMATION

Patient's name _____ Birth date _____ Phone#_____

Social Security number or Driver's License number: _____

If minor, parents/guardian names Mother:_____ Phone _____

Father: _____ Phone _____

Legal Guardian: _____ Phone _____

Mailing address _____ City _____State _____ Zip _____

Email address _____

Spouse's name (If married) _____

Whom may we thank for referring you to our office? _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Subscriber's Social Security #: _____-_____-_____ Subscribers Birth date: ____/____/_____ Dental Insurance Co._____

ID # or Plan # _____ Group # _____ Employer _____

Covered by spouse's insurance? ❑ yes ❑ no

Covered by second insurance? ❑ yes ❑ no Subscriber name _____

Relation to Subscriber ❑ Child ❑ Spouse ❑ Self

Spouse's or secondary dental insurance co. _____ ID# or Plan# _____ Group # _____

Spouse's or secondary birthday _____/_____/_____ Spouse or second Social Security # _____-_____-_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

YES	NO	
❑	❑	Cancer or tumor Type: _____.
❑	❑	Heart ailment or angina
❑	❑	Heart murmur, mitral valve prolapse, heart defect
❑	❑	Rheumatic fever or rheumatic heart disease
❑	❑	Artificial joint or valve
❑	❑	High or low blood pressure
❑	❑	Pacemaker
❑	❑	Tuberculosis or other lung problems
❑	❑	Kidney disease
❑	❑	Hepatitis or other liver disease Type:_____.
❑	❑	Alcoholism/Drug addiction
❑	❑	Diabetes Type : _____.
❑	❑	Epilepsy, seizures, or fainting spells
❑	❑	Emotional condition
❑	❑	Arthritis
❑	❑	Herpes or cold sores
❑	❑	AIDS or HIV positive
❑	❑	Anemia or blood disorders
❑	❑	Abnormal bleeding after extractions, surgery, or trauma
❑	❑	Asthma

Are you allergic to, or have you reacted adversely to any of the following?

❑YES ❑NO	Latex materials
❑YES ❑NO	Penicillin or other antibiotics
❑YES ❑NO	Codeine or other narcotics
❑YES ❑NO	Sulfa drugs
❑YES ❑NO	Barbiturates, sedatives, or sleeping pills
❑YES ❑NO	Aspirin

Other: _____

Are you taking any of the following?

❑YES ❑NO	Aspirin
❑YES ❑NO	Anticoagulants (blood thinners)
❑YES ❑NO	Antibiotics or sulfa drugs
❑YES ❑NO	High blood pressure medicine
❑YES ❑NO	Antidepressants or tranquilizers
❑YES ❑NO	Insulin, Orinase, or other diabetes drug
❑YES ❑NO	Nitroglycerin
❑YES ❑NO	Cortisone or other steroids
❑YES ❑NO	Osteoporosis (bone density) medicine

Other: _____

_____

Women:

❑YES ❑NO May be pregnant

Expected delivery date: _____

Name and phone number of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

Dental concerns? _____

I allow the following person or persons to make medical decisions and receive medical information in reference to my minor child in my absence:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of patient (or parent) _____ Date _____

Sparkle & Shine Family Dental

Financial Policy

The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

- All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.
- All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies and will credit any collections from insurance to the patient's account.
- Fee estimates for dental care can only be extended for a period of six months from the date of consultation.
- Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.
- Any account past ninety (90) days will be sent to collections and have a $30 fee added.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

Acknowledgement of Review of Privacy Practices

I hereby acknowledge that I have reviewed and have been offered a copy of this office's Notice of Privacy Practices explaining:

1) How this office will use and disclose my protected health information.
2) My privacy rights with regard to my protected health information.
3) This office's obligation concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. I also understand that if I have questions or complaints, I may contact:

ABC Dentistry PLC (Sparkle and Shine Family Dental)
5316 S. 3rd Street Louisville, KY 40214 (502) 276-8778

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures.

I understand the above information regarding both the financial policy and privacy practices and agree with its contents.

Patient Name: _____

Responsible Party Name (Self if you're the patient): _____

Patient/Responsible Party Signature: _____ Date: _____

No Show/Late Cancellation Policy
Effective January 1, 2021

Thank you for trusting your dental care to Sparkle and Shine Family Dental. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our new Appointment Cancellation/No Show Policy below:

1. I understand that I will be charged a LATE CANCELLATION fee of $50 if I fail to give at least 24-hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of $50 if I fail to show for my appointment.

3. I understand that if a second NO SHOW/CANCELLATION with no 24-hour notice should occur I may be dismissed as a patient.

4. I understand that these charges are an out-of-pocket expense and that my insurance carrier WILL NOT cover these charges.

By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from Sparkle and Shine Family Dental.

_____

Print Name of Responsible Party Date

_____

Signature of Responsible Party