ABELL IMPLANT
& FAMILY DENTISTRY

Name (Last,First,Middle):____________________ Preferred Name:__________

Street Address:__________________ City:__________ State:______ Zip:________

SS#:______________ Driver's License#:__________ DOB:__________ Age:____

Phone: Home#:__________ Cell#:__________ Work#:__________

Employer:____________________ How long held:__________

Name of Spouse (or parent):______________ DOB:__________ SS#:______________

Driver's License #: __________ Email: __________________

Party Responsible for Paying Account:____________________

How did you hear about our office? __ TV ___ Radio ___ Newspaper/Magazine ___ Billboard

__ Internet __ Family/Friend/Referral:__________

We will be happy to file your insurance for you. Deductibles and co-pays are due at time of service. Payment is due in full if no insurance is involved. We do accept Mastercard, Visa, or Discover for your convenience.

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name: ____________________ Relation to Patient: __________ SS#:______-____-_______

DOB:__________ Employer:______________________________

Insurance Co:__________________ Group#:__________ Member ID#:______________

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name:______________ Relation to Patient:__________ SS#:___-___-____ DOB:__________

Address:______________________________

Insurance Co:__________________ Group#:__________ Member ID#:______________

Please Read and Sign the Following Responsibility and Consent Statement

To the best of my knowledge the above information is complete and correct. I understand that I am responsible for any financial obligation incurred by the services provided. I hereby authorize and request the performance of dental services for myself (or child - if minor) so designated above and give my consent to any advisable and necessary dental procedures, medication, anesthetics, or analgesics to be administered by the attending dentist, or by his supervised staff for dental treatment.

I agree that in order for you to service my account, notify me of information pertaining to my account, or for the purpose of collection, you may contact me by telephone at any number provided by me, including wireless telephone numbers.

Signature: ____________________ Date: __________

Health History

Patient Name: ______________________________________ DOB: _________________

Physician's Name: _________________________ Date of last physical exam: ________________

Pharmacy Name: _____________________________ Phone#: ____________________

Place a mark in the box beside "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes
Anemia	☐ Yes
Arthritis/Rheumatism	☐ Yes
Artifical Heart Valve	☐ Yes
Artifical Joints	☐ Yes ☐ No
Nervous Problems	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No
Bleeding Abnormally Extractions/Surgery	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No
Congestive Heart Failure	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Last A1c: Date:	
Epilepsy	☐ Yes ☐ No
Fainting/Dizziness	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No
Headaches	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No
Heart Problems (other)	☐ Yes ☐ No
Hepatitis - Type:	☐ Yes ☐ No
Herpes - Type:	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No

Jaundice	☐ Yes ☐ No
Jaw Pain	☐ Yes ☐ No
Kidney Disorders	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
COPD/Bronchitis/Emphysema	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Other Respiratory Disease	☐ Yes ☐ No
Radiation Treatment	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No
Scarlet Fever	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No
Sinus Trouble	☐ Yes ☐ No
Skin Rash	☐ Yes ☐ No
Special Diet	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Swollen Feet/Ankles	☐ Yes ☐ No
Swollen Neck Glands	☐ Yes ☐ No
Thyroid Disease Hypo/Hyper	☐ Yes ☐ No
Tonsillitis	☐ Yes ☐ No
Tumor/Growth One Head/Neck	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No
Ulcer	☐ Yes ☐ No
Veneral Disease	☐ Yes ☐ No
Weight Loss (Unexplained)	☐ Yes ☐ No

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Have you ever been hospitalized? Yes: __ No: __ Reason:___________________________________

Are you currently taking: __Anticoagulants (Blood Thinner) __Medication for osteoporosis or osteopenia

List any medications you are currently taking and the correlating diagnosis:

____

____

Allergies:

Aspirin	☐Yes	Latex	☐Yes
Penicillin	☐Yes	Local Anesthetic	☐Yes
Codeine	☐Yes	Barbiturates (Sleeping Pills)	☐Yes
Iodine	☐Yes		

Other Allergies:

____

____

____

____

Are there any other medical conditions that you have had or are currently suffering from? Please Explain.

____

____

____

____

Women:

Are you Pregnant?	☐Yes ☐No	**Due Date:**		
Are you Nursing?	☐Yes ☐No	Taking Birth Control Pills?	☐Yes ☐No	

Updated On: __________

Updated On: __________

Updated On: __________

Updated On: __________

Updated On: __________

Appointment Change Policy

Abell Implant and Family Dentistry requires 24-hour notice for any appointment change. If 24-hour notice is not received there will be a $25.00 charge. This charge is not a covered benefit by your insurance company and will be your responsibility. Abell Implant and Family Dentistry will not be able to re-schedule any dental appointments until this charge is paid.

I, ______________________________, have reviewed and understand Abell Implant and Family Dentistry's policy for appointment change without a 24-hour notice.

____
Patient's Signature or Parent/Guardian's Signature

____
Date

Returned Check Policy

There will be a $25.00 charge for each check returned to us due to insufficient funds. No appointments will be made until this fee, as well as the outstanding balance, has been paid.

I, __________________, have reviewed and understood Abell Implant and Family Dentistry's returned check policy.

____
Patient's Signature or Parent/Guardian's Signature

____
Date

ABELL IMPLANT
& FAMILY DENTISTRY

Daniel F. Abell, D.M.D.
4975 Alben Barkley Dr. Ste. 3
Paducah, Kentucky 42001
(270) 554-3031

Notice of Privacy Practices Patient Acknowledgement

Patient Name: ______________________________ Date of Birth: ___________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____ Date: _______________

Relationship to patient (if signed by a personal representative of patient): ______________________