The Center for Aesthetic & Implant Dentistry

12010 Shelbyville Rd. Louisville,
Kentucky 40243 tel 502-589-4671
email: info@smilelouisville.com
www.smilelouisville.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____Email: _____

Patient Number: _____Social Security Number:_____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting.

This office at 12010 Shelbyville Road, Suite 100
Phone: (502) 589-4671 Fax: (502) 589-6584

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature _____Date:_____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the Patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked by Consent.

Signature: _____Date:_____

The Center for Aesthetic & Implant Dentistry

Bryan T. Harris, D.M.D. | Taylor Ruby, D.M.D

12010 Shelbyville Road, Ste. 100
Louisville, Kentucky 40243
502-589-4671
Email: info@smilelouisville.com

I, _____authorize the release of information concerning dental care history for the following patient'(s) to the office below.

Patient(s) Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Date(s) of Birth: _____

Transfer Records To:

Dr. Bryan T. Harris and Dr. Taylor Ruby
12010 Shelbyville Road, Ste. 100
Louisville, Kentucky 40243
Email: info@smilelouisville.com

_____ _____
Patient or Guardian Authorized Signature Date

_____ _____
Office Signature Date of Transfer

The Center for Aesthetic & Implant Dentistry

BRYAN T. HARRIS, DMD/ TAYLOR RUBY, DMD

12010 Shelbyville Rd.
Louisville, Kentucky 40243
tel 502-589-4671/ info@smilelouisville.com
SmileLouisville.com

MEDICAL HISTORY QUESTIONNAIRE

First Name: _____ Last Name _____ Date _____

Date of Birth: _____ Age: _____ Sex: _____ Height _____ Weight _____

For the following questions, circle or select YES or NO, whichever applies.
Your answers are for our records only and will be kept confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. Physician Name _____ Phone _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
   Please explain _____
   _____
7 Have you had an artificial joint replacement (knee, hip, etc.)? What year? ..... Yes No
8 Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia)? Please circle one if yes ..... Yes No
9a. Are you taking any blood thinners? (Xarelto, Coumadin, Plavix, Pradaxa, Aggrenox, Aspirin) Please circle one if yes ..... Yes No
9b. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? ..... Yes No
   If so, please list _____
   _____
   _____
   _____
10. Do you have or have you had any of the following diseases or problems? If yes, please explain
    a. Artificial valves, heart murmur, or mitral valve prolapse ..... Yes No
    b. Rheumatic Heart Disease, damaged heart valves ..... Yes No
    c. Heart trouble, heart attack, angina, stroke, arteriosclerosis or any other heart condition ..... Yes No
       1. Chest pain upon exertion? ..... Yes No
       2. Shortness of breath after mild exercise? ..... Yes No
       3. Do your ankles swell? ..... Yes No
    d. High Blood Pressure ..... Yes No
    e. Sinus trouble ..... Yes No
    f. Asthma ..... Yes No
    g. Fainting spells or seizures ..... Yes No
    h. Diabetes ..... Yes No
    i. Hepatitis, jaundice or liver disease ..... Yes No
    j. Frequent or recurring mouth sores ..... Yes No
    k. Thyroid problems ..... Yes No
    l Respiratory problems, emphysema, bronchitis, COPD ,etc. ..... Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
    n. Osteoporosis ..... Yes No
    o. Stomach ulcer or colitis ..... Yes No
    p. Kidney disease ..... Yes No
    q. Tuberculosis ..... Yes No
    r. Persistent cough or cough that produces blood ..... Yes No
    s. Persistent swollen neck glands ..... Yes No

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t. Low blood pressure ..... Yes ○ No
u. Epilepsy or neurological disorder ..... Yes ○ No
v. Cancer ..... Yes ○ No
w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes ○ No

11. Have you had abnormal bleeding? ..... Yes ○ No
    a. Have you ever required a blood transfusion? ..... Yes ○ No
12. Do you have any blood disorder such as anemia? ..... Yes ○ No
13. Have you ever had treatment for a tumor or growth? ..... Yes ○ No
14. Have you had radiation therapy to the head, neck or jaws? ..... Yes ○ No
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes ○ No
    b. Penicillin or antibiotics ..... Yes ○ No
    c. Sulfa drugs ..... Yes ○ No
    d. Barbiturates or sleeping pills ..... Yes ○ No
    e. Aspirin ..... Yes ○ No
    f. Iodine ..... Yes ○ No
    g. Codeine or other narcotics ..... Yes ○ No
    h. Latex or rubber products ..... Yes ○ No
    i. Other *(please list name of medication)* ..... Yes ○ No
16. Have you had any serious trouble associated with previous dental treatment? ..... Yes ○ No
    If so, explain _____
17. Do you have any other condition or disease you think the doctor should know about? ..... Yes ○ No
    If so, explain _____
18. Do you smoke or chew Tobacco? ..... Yes ○ No
    How much? _____ How long ? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes ○ No
20. Are you wearing contact lenses? ..... Yes ○ No
21. Are you wearing removable dental appliances? ..... Yes ○ No
22. Do you wish to talk with the doctor privately about anything? ..... Yes ○ No

Women

Are you pregnant or any chance you might be pregnant? ..... Yes ○ No
Are you nursing? ..... Yes ○ No
Are you taking birth control pills? (If so, antibiotics and some other medications may interfere with the effectiveness of birth control. Consult with your physician.) ..... Yes ○ No

Chief Dental Complaint

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient's Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying and locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose you health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, such as, voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: You have the right to look at your get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must made a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable, cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information, in response to a request you made to amend or restrict the use or disclosure or your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Ellen Taylor

12010 Shelbyville Road, Suite 100
Louisville, KY 40243
Phone: (502) 589-4671

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Confidential Patient Information

(Please Print Legibly)

Date: _____

Personal Information

Name:_____ SSN: _____

Address: _____

City:_____ State: _____ Zip: _____

Telephone: (Home)_____ (Work)_____ (Mobile) _____

Email:_____ Date of Birth: _____ Sex: M F

Marital Status: _____ Spouse Name: _____

Employer: _____ Referred By: _____

Person Responsible for Account

Name: _____ Relationship: _____ SSN: _____

Address: _____Date of Birth:_____

City:_____ State: _____ Zip: _____

Dental Insurance Information

Primary Insurance Company:_____

Insurance Company Address:_____

Policy Holder: _____ Relationship: _____ SSN: _____

Employer: _____ Policy Number: _____

Secondary Insurance Company:_____

Insurance Company Address:_____

Policy Holder: _____ Relationship: _____ SSN:_____

Employer: _____ Policy Number: _____

I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature: _____ Date:_____

INFORMATION FOR OUR PATIENTS WITH DENTAL INSURANCE

Dental insurance is playing a larger and larger role in helping people obtain dental treatment. Since we feel strongly that our patients deserve the best dental care we can provide, and in effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

We consider our relationship with you to be of primary importance and will always make our recommendations to you based on what we believe is the very best treatment for your regardless of your insurance coverage. As the patient, it is your responsibility to deal with your insurance company and your employer. We will assist in any way possible to maximize your dental insurance benefits, but to reemphasize. We have no relationship or responsibility to your insurance company.

FACT #1: Dental insurance is not meant to be "PAY-ALL," it is only meant to be an aid

FACT #2: Many plans tell their insured that they will be covered "up to 80%" or "up to 100%." In spite of what you are told, we have found many plans cover 40% to 50% of an average fee. Some plans pay more...some pay less. The amount your plan pays is determined by the contribution you and your employer make to your dental plan. The smaller the contribution paid into the plan for "insurance" the less you will receive. It is your responsibility to advise us of your insurance coverage restrictions.

FACT #3: **I**t has been the experience of many dentists that some insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying to them that "our benefits are low." Remember, you get back only what you and your employer put into your insurance coverage less the profits of the insurance company. In dealing with over 1,000 dental insurance plans, most plans do cover our fee.

FACT #4: Each plan utilized in our office has different percentages, deductibles, maximums, procedures covered and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible of what your insurance plan will cover. However, we cannot estimate precisely. There may be variances for what the patient is individually responsible.

FACT #5: Insurance carriers do NOT cover many routine dental services. We make our recommendations based on your needs and not on what your insurance may or may not cover.

Please do not hesitate to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. We will fill our and file insurance forms at no charge. We will do all we can to assure you of your maximum benefits.

If you have any questions regarding your insurance, please contact your insurance carrier regarding the specifics and details of the plan they are operating on your behalf.

- ☐ I authorize the release of all necessary information
- ☐ I authorize payment of benefits directly to the provider
- ☐ I have read this form and agree to be financially responsible for all fees regardless of insurance coverage

Signature:_____ Date: _____