KENWOOD ADVANCED DENTISTRY LLC

GENERAL-COSMETIC-IMPLANT-BOTOX-DERMAL FILLER PROVIDER

MICHAEL PRATER D.M.D.

WELCOME! Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental care needs please fill out this form completely!

PATIENT INFORMATION (*CONFIDENTIAL*)

First: _____ Last: _____ Preferred: _____ Birthdate: ___/___/_____

Address: _____ Social Security: ___-___-_____

City: _____ State: _____ Zip code: _____

Mobile #: _____ Home #: _____ Work#: _____

Check status: ___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Email: _____

Employer: _____

Emergency Contact: _____ Relationship: _____ Phone #_____

RESPONSIBLE PARTY (*IF DIFFERENT FROM PATIENT*)

Responsible Party Name: _____ Contact number: _____

Billing Address: _____

City: _____ State: _____ Zip code: _____

Relationship to Patient: _____

Preferred Payment Method: (*Circle One*) Credit card Check Cash per Visit

DENTAL INSURANCE INFORMATION

Please Print everything as it appears on the Dental Insurance Card!

Name of Dental Insurance: _____

Subscribers First/Last Name: _____ Subscribers DOB: ___/___/_____

Subscribers Social Security # **or** Alt. Members ID **or** Policy ID: _____

Group Number: _____ Dental Providers Phone Number: _____

Claims Address: _____

City: _____ State: _____ Zip code: _____ Payer ID: _____

Effective Date: ___/___/_____ Insurance Plan Year Run: *CALENDAR* or *CONTRACT* Months: _____-_____

Plans Maximum: _____ Individual Deductible: _____ Family Deductible: _____

ADDITIONAL DENTAL INSURANCE INFORMATION

Please Print everything as it appears on the Dental Insurance Card!

Name of Dental Insurance: _____

Subscribers First/Last Name: _____ Subscribers DOB: ___/___/_____

Subscribers Social Security # **or** Alt. Members ID **or** Policy ID: _____

Group Number: _____ Dental Providers Phone Number: _____

Claims Address: _____

City: _____ State: _____ Zip code: _____ Payer ID: _____

Secondary Insurance Maximum: _____ and Deductible: _____ Family Deductible: _____

PATIENT MEDICAL AND DENTAL HISTORY:

What brings you in for today's visit? _____
Date of your prior Dental visit? ___/___/_____ Office/Dentist Name: _____
What procedures were completed? _____
Do you have a history of trouble getting numb or blood drawn? _____
If yes explain: _____
Have you ever been hospitalized or under medical treatment with in the last 5 years: YES or NO
If YES explain: _____
Are you currently taking any medication(s) including non-prescription medicine, controlled substance, or Vitamins:

_____

_____

WOMEN ONLY: *(CIRCLE WHAT APPLYS TO YOU)* PREGNANT NURSING TAKING ORAL CONTRACEPTIVES

Please check X if you have or had the following:

__ High Blood Pressure	__ Hepatitis/Jaundice	__ Codeine Allergy
__ Low Blood Pressure	__ Sexually Trans. Disease	__ Penicillin Allergy
__ Heart Trouble	__ Stroke	__ Latex Allergy
__ Rheumatic Fever	__ Hay Fever	__ Nickel Allergy
__ Fainting/Seizures	__ Joint/Knee Replacement	__ Mercury Allergy
__ Asthma	__ Tuberculosis	__ Seasonal Allergy
__ Radiation Therapy	__ Sinus Issues	
__ Cancer	__ Glaucoma	__ Sulfa Drug Allergy
__ Diabetes	__ Liver Disease	__ Use of tobacco
__ Kidney Disorder	__ Kidney Stones	__ Taking Aspirin
__ AIDS/HIV Infection	__ Mitral Value Prolapse	__ Heart Murmur
__ Thyroid Problems	__ Excessive Bleeding	__ Blood Disease
__ Cardiac Pacemaker	__ Mental Disorder	__ Flagel
__ Anemia	__ Pre-Med	__ Tremor
__ Arthritis	__ Stomach Problems	__ Ulcers
__ Angina	__ Emphysema	__Epilepsy

List of Allergies that are not included: _____

ETC., DENTAL QUESTIONS TO GET TO KNOW YOU ALITTLE MORE

1. How often do you brush and floss your teeth? _____
2. Are your teeth usually sensitive to hot or cold when eating and drinking? _____
3. Do your gums tend to bleed while brushing or flossing? _____
4. Any issues with TMJ, Clenching, Grinding, or Clicking in the jaw? _____
5. Do you wear dentures or partials? _____
6. Do you like your smile? _____

AUTHORIZATION AND RELEASE *– I certify that I have read and understand the above information was answered correctly to the best of my knowledge. I authorize the dentist to release my/childs information including records, diagnosis, treatment, dental care of third payers and /or health practitioners. I authorize my insurance company to pay directly to dentist or dental group benefits. I understand my dental insurance does not cover all procedures, and any out of pocket cost are billable to me or responsible party.*

Patients Signature: _____ Date: ___/___/_____

Kenwood Advanced Dentistry LLC

Michael L Prater DMD

Consent for use and disclosure of health information/records

Name: _____

Address: _____

Telephone: _____

Section B: To the patient. Read the following statements carefully. Section A: Patient giving consent.

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 health records.

Notice of Privacy Practice: 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 your treatment, payment activities, and health records, of the users 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 complete 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 practice, 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:

Contact Person: _____

Telephone: (513)-793-3722 **Fax:** (513)-793-2706

Address: 8040 Hosbrook Road STE 230, Cincinnati Ohio 45236 **Email:** mpraterdmd@hotmail.com

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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 Consent Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance in this Consent before we receive your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

Signature:_____

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

SIGNATURE:_____ **DATE:** ____/____/_____

**IF THIS CONSENT IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:*

*NAME:*_____ *RELATIONSHIP To PATIENT:* _____

KENWOOD ADVANCED DENTISTRY

MICHAEL PRATER D.M.D
8040 HOSBROOK ROAD, SUITE 230 CINCINNATI OH 45236
PHONE: 513-793-3722

Financial Policy Acknowledgement

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our of our business team.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the Quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, Visa, MasterCard, Discover and American Express. We have also partnered with a third-party company, CareCredit to offer the flexibility of deferred interest and extended payment options.

-We will communicate all recommended treatment options and associated fees to the best of our ability prior to the start of treatment. Payment is due at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered. As a courtesy to our patients with dental insurance benefits, we will submit claims to insurance on your behalf. We require that any applicable deductibles and estimated patient portion be paid AT the time treatment is rendered. We do accept the assignment of insurance benefits to help reduce your immediate out-of-pocket expense.

-Please contact your insurance prior to your visit to obtain essential information which will accurately reflect your coverage. If you have direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

-Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.

-It is your responsibility to understand the type of dental insurance you have (i.e. , Traditional, PPO or DMO) and the benefits selected by you and/or your employer.

-You (not the insurance company) are responsible for the fees of services rendered. Should insurance fail to remit payment for services rendered within 90 days from the date of service, you are responsible for the fees of services rendered. As a courtesy to keep you informed, accounts with an outstanding balance will receive a statement every 30 days, regardless of pending insurance.

Patient/Parent/Guardian Signature: Date