We are pleased to welcome you to our practice. *Please take a few minutes to fill out this form as completely as you can. We are looking forward to working with you on maintaining your health.*

Patient Information

Patient _____ Sex: M F DOB: _____ Marital: S M W D
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell _____ SS # _____ Pharmacy _____
Email _____ Occupation/Employer _____ Work Phone _____
Who should be notified in case of an emergency? _____ # _____
How would you prefer for us to contact you? Home phone ☐ Work phone ☐ Cell phone ☐
Whom may we thank for referring you to our office? _____

Primary Dental Insurance

Insured's Name _____ Relationship _____ DOB _____ SS# _____
Address _____
Employer _____ Insurance Co. _____

Secondary Dental Insurance

Insured's Name _____ Relationship _____ DOB _____ SS# _____
Address _____
Employer _____ Insurance Co. _____

Medical History

Former Dentist _____ Address _____ Phone # _____
Physician's Name _____ Phone # _____ Last Visit _____
Are you currently under a physician's care? _____ If yes, describe _____
Have you ever been hospitalized, had major operations or serious illness? _____
Have you ever had a blood transfusion? _____ If yes, give approximate dates _____
Women: Do you suspect that you are pregnant? _____ Are you nursing? _____ Do you take birth control pills? _____
Do you use any tobacco products? _____ What kind? _____ How long? _____ How much per day? _____

Please check if you currently have, or have ever had any of the following:

__ Mitral Valve Prolapse
__ Heart Murmur
__ Heart Conditions
Describe: _____
__ Rheumatic Fever
__ Rheumatic Heart Disease
__ Artificial Heart Valve
__ Artificial Joints
__ Swelling of the Feet/Ankles
__ Respiratory Disease
__ Glaucoma
__ Epilepsy
__ Diabetes
__ Cancer, Tumors
__ Chemotherapy, Radiation
__ Sinus Trouble
__ Asthma
__ Hives, Skin Rashes
__ AIDS, HIV Positive
__ Liver Disease
__ Jaundice
__ Hepatitis, Type __
__ Arthritis
__ Material Allergies: LATEX, Metal, Chemicals
__ Tuberculosis
__ Persistent Cough
__ Cough Up Blood
__ Ulcers, Stomach or Intestinal Problems
__ High or Low Blood Pressure
__ Venereal Disease
__ Anemia

Are you taking or have you ever taken bone replacement medications? (Ex. Boniva, Fosamax, Actonel, Zometa, etc.) _____
_____
List any medications you are currently taking _____
_____
_____
List any drug allergies _____

- I authorize the release of my dental records and medical information to Dr. Michael E. Pope.
- I consent to treatment considered necessary by the dentist or qualified designate.

Signature _____ **Date** _____

Michael E. Pope, D.M.D., P.S.C.
152 Parker's Mill Road, Suite A
Somerset, KY 42501

FINANCIAL POLICY

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, **we cannot guarantee any estimated coverage**. Because the insurance policy is an agreement between **you and the insurance company,** we ask that all patients be directly responsible for all charges. We appreciate your notifying us of any changes in your coverage promptly as the insurance company has no obligation to notify us of changes. Please know we will do everything possible to see that you receive the full benefits of your policy. If for some reason your insurance company has not paid their portion within 30 working days from the date of treatment, you are responsible for payment at that time. (Federal law mandates that insurance companies act on insurance claims within 30 working days.) **A 1-1/2% per month interest rate will be added to any balances over 45 days old. All deductibles and co-payments are due at the time of service**. We will file your pre-treatment estimates as a service to you. Please be aware that pre-determinations do not guarantee payment. Further, insurance companies have a yearly and sometimes a lifetime maximum, and it is entirely your responsibility to keep track of this yourself. **You will be responsible for any charges not covered**.

PAYMENT OPTIONS

Cash or Check:	We are happy to offer a 5% pre-payment courtesy for all treatment plans paid in full prior to treatment.
Credit Cards:	For your convenience, we have made arrangements to accept payment by several major credit cards.
Payment Plan:	For qualified patients who desire a monthly payment plan, we have made arrangements with a finance company. There are no application fees or down payment and the loan can be interest free for 12 months. Other options may be available for those patients who qualify.

--I have read and understand this financial policy.
--I authorize payment of dental benefits to Michael E. Pope, D.M.D., P.S.C.
--I understand that credit bureau reports may be obtained in case I request financing of treatment.

_____ _____

Signature Date

SOUTHERN DENTAL · GROUP

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. PLEASE READ IT CAREFULLY.

Dr. Michael E Pope is dedicated to protecting your medical information. We are requested by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. Dr. Michael E Pope is required by law to abide by the terms of this notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the dentist treating you, by the business office to process your payment for the services rendered and by administrative personnel reviewing the quality of the care you receive. We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

- Appointment recall cards
- Disclosure to Dept. of Health & Human Services
- Notification to a family member of person of your choice
- Persons involved in your care
- Interpreter
- School for confirming child was present for a visit
- As required by law
- Abuse or neglect
- Law enforcement
- Coroners, medical examiners & funeral directors
- Public safety
- Business associates

PATIENT RIGHTS:

- Access to your medical record
- Restrictions about uses and disclosures
- Right to receive an accounting of disclosures made after 4/14/2003
- Request a copy of this notice
- Right to complain to us and/or U.S. Dept of Health & Human Services

If you would like further information regarding your rights, you may contact

Michael E Pope, DMD
152 Parkers Mill Rd Ste A, Somerset, KY 42501
Phone 606-678-0874
Contact Person: Rebecca

THIS NOTICE IS EFFECTIVE AS OF 4/14/03

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of (Provider) Notice of Privacy Practices.

Name_____

Signature_____

Date_____

You may refuse to sign this acknowledgement

For (Provider) Use Only

We made every attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Above named individual refused to sign

_____ Emergency situation prevented obtaining signature

_____ Other (Please specify)

_____

_____

_____

_____

_____