Advanced Dental Care of Central Kentucky
Paula K. Lenox, DMD
1154 Lexington Road
Building C, Suite 2
Georgetown, KY 40324
(502)863-2207
www.drlenox.com

Dear Patient,

Welcome! We are extremely pleased you have chosen to join our dental family.

Your health, comfort and smile appearance is our primary concern. You will find the entire team is dedicated to improving your dental health as quickly as possible through our expert and compassionate care. During your first visit, we will provide an examination, take necessary x-rays, and make home care recommendations. The patient's portion for services rendered is expected at the conclusion of the visit.

Patients of our office appreciate the benefits of comprehensive and continued, thorough care. Today's dentistry is for everyone who wants to enjoy a lifetime of smiles. In some cases more than one appointment is necessary for us to obtain all of the data needed to accurately diagnose and treat your current oral health.

Except for emergency situations, you can expect us to be on time for you. We are committed to being here for you and we appreciate the same in return. If you must cancel or reschedule an appointment, please give us the courtesy of 24 hours notice.

Enclosed you will find our Patient Information , Health/Dental History, Treatment Consent, Financial forms, Smile Evaluation, Handle With Care Form and Privacy Practices Brochure. Please read, complete and sign. Bring all the completed forms with you to your first visit.

If at any time you have a question about any treatment, fee or service, please feel free to discuss it with us promptly and openly. Your comfort, both dental and financial, is important to us and we will make every effort to work with you to achieve that goal. We look forward to seeing you! It is my hope that we may give you plenty to smile about.

Sincerely,

Paula K. Lenox, DMD

Chart #:
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home):_____ (Cell):_____ *(Work):* _____(Other): _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐Th

Address: _____
Street Apartment #

_____
City State Zip Code

Email: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Insurance ☐ Internet ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Account Guarantor

(If other than Patient)

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

I agree to be financially responsible for the above patient's account _____ _____
Signature Date

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment Phone Number: _____

Employer Name:_____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information (Primary)

Name of Subscriber: _____
Last First MI

Subscriber's Birth Date: _____ SS #: _____ Group/ Policy #:_____

Address(if different from patient): _____
Street City State Zip Code

Subscriber's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Company Name: _____
Address: _____ Phone #: _____

_____

Insurance Authorization

I hereby authorize my insurance company to pay Dr. Lenox directly. I understand that I am responsible for all costs of dental treatment regardless of insurance coverage. This signature is the equivalent of signing an insurance form. It will remain on file to be used as needed to file insurance for me.

_____ Date _____
Signature of Patient, Parent or Guardian

Hygiene Consent

In the state of Kentucky, hygienists are permitted to work under general supervision (without a doctor physically present in the office. In the event that the practicing dentist is not present the day of hygiene treatment, I consent for the hygienist to perform dentistry in the scope of her defined duties. This applies for any future treatment.

_____ Date:_____ Relationship to Patient:_____

Signature of patient, parent or guardian

Consent to Perform Dentistry/ Service

1. I hereby authorize and direct Dr. Paula K. Lenox and/or the dental auxiliaries of her choice, to perform the following treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

A. Radiographs (x-rays) of teeth and jaw.
B. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
C. Application of plastic "sealants" to the grooves of the teeth.
D. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
E. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures).
F. Removal (extraction) of one or more teeth.
G. Treatment of diseased or injured oral tissues (hard and/or soft).
H. Use of sedative drugs to control apprehension and/or disruptive behavior.
I. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of Dr. Lenox. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from these discussed. I therefore authorize and request that performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of Dr. Lenox.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in the respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research, and scientific publications.

7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that the regular office visits as scheduled by my dentist and her auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

HEALTH HISTORY

Correct answers to the following questions will allow Dr. Lenox to treat you on an individual basis.
The following information is essential for this office to provide dental care that is compatible with your general health.
Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently.
Incorrect information can be dangerous to your health.
*** Answer by circling Y (yes) or N (no)***

Patient's Name _____ **Birth Date** _____
Primary Physician _____ **Physician Number** _____
Are you in good health now? Y N
Are you currently under the care of a physician? Y N For what condition? _____
In the past five years, have you been hospitalized for a serious illness? Y N
If yes, please explain:
_____
Have you ever had excessive bleeding after an extraction or cut? Y N
Do you use tobacco in any form? Y N If yes, how much? _____

DO YOU HAVE OR HAVE YOU EVER HAD:

CARDIOVASCULAR DISEASE:			KIDNEY DISEASE:	Y	N
Rheumatic Fever?*	Y	N	LIVER DISEASE:		
Heart Murmur?*	Y	N	Jaundice?*	Y	N
Chest Pains?	Y	N	Hepatitis?	Y	N
Heart Attack?	Y	N	ENDOCRINE:		
High Blood Pressure?	Y	N	Diabetes?*	Y	N
Artificial Heart Valve?	Y	N	Thyroid Problems?	Y	N
Stroke?	Y	N	BONE:		
Coronary Artery Disease?	Y	N	Osteoporosis?	Y	N
Palpitations?	Y	N	Arthritis?	Y	N
Pacemaker?*	Y	N	Rheumatoid Arthritis?	Y	N
Mitral Valve Prolapse?*	Y	N	Artificial Joint?*	Y	N
SKIN DISORDERS:			BLOOD DISEASE:		
Hives?	Y	N	AIDS/HIV Infection?	Y	N
Herpes/Cold Sores?	Y	N	Bruise Easily?	Y	N
LUNG DISEASE:			Blood Transfusion?	Y	N
Tuberculosis?*	Y	N	Hemophilia?*	Y	N
Emphysema?	Y	N	Low Blood Pressure?	Y	N
Asthma/Hay fever?	Y	N	OTHER:		
Chronic Cough?	Y	N	Latex Allergy?*	Y	N
Bronchitis?	Y	N	Sinus or Nasal Problem?	Y	N
NEUROLOGICAL DIORDERS:			Stomach Ulcers:	Y	N
Convulsions/Epilepsy?	Y	N	Colitis?	Y	N
Dizziness?	Y	N	Glaucoma?*	Y	N
Migraines?	Y	N	Loss of Hearing?	Y	N
Fainting?	Y	N	Eating Disorders?	Y	N
WOMEN:			Malnutrition?	Y	N
Use Birth Control?	Y	N	Sleep Disorders?	Y	N
Pregnant?	Y	N	Cancer?	Y	N
Nursing?	Y	N	Radiation Treatment?	Y	N

Any disease, drugs, or transplant operations which may have depressed your immune system? Y N
If yes, please explain _____
Any problems with anesthesia? Y N

Patient Signature _____ Date _____

Please List ALL Medications:

Include prescription, over the counter, and herbal medications

_____
_____
_____
_____
_____

Please List ALL Allergies:

Local anesthetics, penicillin, aspirin, latex, etc.

_____
_____
_____
_____
_____

Dental History

Are you aware of any dental problems? ***Y / N***
What? _____
Are you in any pain? ***Y / N*** *What causes the pain ---* ***Hot Cold Biting Pressure Sweets***
How long does the pain last? _____
Taking medication for the pain? ***Y / N*** *What?* _____
How long has this been a problem? _____ ***Days Weeks Years***

PAST DENTAL HISTORY:

When was your last dental visit? _____
What was done? _____
Have you made regular visits to the dentist? ***Y / N***
When were your last x-rays taken? _____
Which ones? _____
Were there any complications after extractions? ***Y / N***

Think about your previous dentists and dental experiences:

What were the things you liked? _____
Disliked? _____
Have you ever had a bad experience? _____

ORAL HYGIENE:

How often do you brush? _____
How often do you floss? _____
Does food get caught between your teeth? ***Y / N***
Have offensive breath? ***Y / N*** *Bad taste?* ***Y / N***

TMJ:

Do you clinch or grind your teeth? ***Y/N***
Does your jaw ever pop or click? ***Y / N***
Ever lock? ***Y / N***
Do you have problem opening or closing? ***Y / N***
Do you have headaches in the morning when you awake? ***Y / N***
Does your jaw ever hurt? ***Y / N***

TEETH:

Do you think your teeth are moving or drifting? ***Y / N***
Do they feel sore when biting? ***Y / N***
On a scale from one to five with one being the least and five being the most:

How important are your teeth to you?	***1***	***2***	***3***	***4***	***5***
How important is the appearance of your smile?	***1***	***2***	***3***	***4***	***5***
How committed are you to obtaining your dental health?	***1***	***2***	***3***	***4***	***5***

HABITS:

Do you use tobacco in any form? ***Y / N*** *How often?* _____ *For how long?*_____
Do you regularly use alcohol? ***Y / N*** *Any other drugs?* ***Y / N***
Do you chew gum often? ***Y / N*** *Suck on candy?* ***Y / N*** *Suck on lemons?* ***Y / N***
Any other habits that you feel may affect your teeth or mouth? _____

Additional comments, questions, concerns?

_____
_____
_____
_____

********** *FOR OFFICE USE ONLY*********

ASA type: I II III IV
History review and significant findings:

_____
_____
_____
_____
_____

Doctor's Signature _____ *Date* _____

FINANCIAL POLICY

Thank you for choosing our practice for your dental care, we are privileged that you are here! Our focus is you, our patient and we take pride in caring for you as we do our own families. The goal of our entire staff is to ensure you have the optimum in dental care and will work to overcome any obstacle that may prevent you from completing any recommended treatment. In order to maintain a positive professional relationship, it is important that we outline our financial policies to provide clarity and to establish a clear understanding of financial responsibilities.

SECTION I ____I have dental insurance

(Please read and initial all items in section I)

___Your policy is a contract between you, your employer and the insurance company. We are not responsible for your policy provisions or limitations on your policy. We strive to gather the most accurate information available from your carrier but are limited to the information your carrier will give us.

____ Our office will verify your dental coverage. You are required to submit your insurance card and photo I.D. to the office upon check in. If your coverage changes, you are asked to submit your updated information to the office before charges are applied to your account.

____As a courtesy, our office will submit the dental claims on your behalf. However, you are required to pay the ***estimated*** co-payment at the time of service. We accept cash, checks, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and CARE CREDIT as options for your co-payment.

___If your insurance carrier does not pay for services or pays less than estimated by your plan provisions provided, you are responsible to pay the balance in full upon receipt of your monthly statement**.**

____Any account balances remaining beyond 90 days will bear interest at 1.5% per month, which is 18% annum.

SECTION II ____I do not have dental insurance

(Please read and initial all items in Section II)

__ Balance for services is due at the time of service. Other financial arrangements must be secured prior to starting any dental treatment if payment for services is not possible.

__ We accept cash, checks, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and CARE CREDIT as options for your payment. Any third party financing must be confirmed before treatment is started.

I understand the financial & appointment policies of this practice and agree to abide by them.

Signature of patient or representative: _____

Date: _____**Staff Initials**_____

Patient Smile Interview

We would like to help you obtain the smile you've always wanted!
Please take a few minutes to complete this short questionnaire.
While using a mirror or looking at a photograph, please observe your teeth carefully.

1. Do you have any concerns about bad breath odor? YES / NO

2. Are you pleased with the appearance of your teeth when you smile? YES / NO

3. Are you pleased with the color of your teeth? YES / NO

4. Are you pleased with the shape of your teeth? YES / NO

5. Are there spaces between your teeth that you don't like? YES / NO

6. Are your teeth…. Chipped? YES / NO
   Protruding? YES / NO
   Hidden? YES / NO
   Crowded? YES / NO

7. Do you like the way your teeth fit together? YES / NO

8. Are there any old fillings or dental treatment that you aren't happy with? YES / NO
   If yes, please explain…

_____
_____
_____

9. If you could change anything about the appearance of your smile, what would it be?

_____
_____
_____

10. Is there anything about the shape or alignment of your jaws that you are not happy with?

_____
_____
_____

Please Handle Me With Care

Put a check mark in the box next to the statements that concern you or describe how you feel.

☐ I gag easily.

☐ I feel out of control when I am lying down in the chair.

☐ I have not been to the dentist for a long time and I feel uncomfortable about what you will say or think about my teeth and my dental hygiene.

☐ I know I have bad habits that are causing harm to my dental health. I am afraid I might not be able to break them.

☐ Pain relief is a top priority to me.

☐ I don't like shots, or I've had a bad reaction to shots.

☐ Please tell me what I need to know about my mouth so I can make an informed decision.

☐ My teeth are very sensitive.

☐ I don't like the sound of that tool that makes the picking and scraping noise.

☐ I don't like cotton in my mouth.

☐ I hate the noise of the drill.

☐ Please respect my time. I don't want to be left sitting in the reception area.

☐ I want to know the cost up front. No money surprises, please.

☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.

☐ I have health problems and questions that we need to discuss.

☐ I don't like being left alone in the treatment area.

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of and
(Please Print Name)

understand this dental office's Notice of Privacy Practices.

_____ _____
Signature Date

You May Refuse to Sign This Acknowledgement

****

For Office Use Only

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

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)
_____
_____
_____