



8076 U.S Highway 42  
Florence, KY 41042

Website: dcof.com  
Phone: 859-282-9741  
Fax: 859-282-2171

Laura J. Herfel, DMD & Keith A. Laws, DMD  
Megan P. Herfel, DMD  
Lionel P. Mayo, DMD  
Tara L. Ryle, DMD

Dental Center of Florence KY, PSC

Patient Information

Name Birth Date
Street Address
City State Zip
Home Phone Cell Phone Soc. Sec. #
Check Appropriate Box: Child Single Married Other
Patient's or Parent's Employer Work Phone
Business Address
City State Zip
Spouse or Parent's Name Work Phone
If Patient is a Student, Name of School/College City State
Whom May We Thank for Referring You?
Person to Contact in Case of Emergency Phone

Responsible Party

Name of Person Responsible for this Account Relationship to Patient
Address Home Phone
Driver's License # Birth Date
Employer Work Phone
Is this Person Currently a Patient in our Office? Yes No

Insurance Information

Name of Insured Relationship to Patient
Birth date Social Security #
Name of Employer
Insurance Company Group # Union or Local #

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured Relationship to Patient
Birth date Social Security #
Name of Employer
Insurance Company Group # Union or Local #

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No		Yes	No
1. Are you under medical treatment now? .....	<input type="checkbox"/>	<input type="checkbox"/>	7. Are you allergic to or have you had any reactions to the following?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any Surgical operation or serious illness? .....	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (eg. Novocaine) .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) Including non-prescription medicine? .....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other Antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Sulfa Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Barbiturates .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use tobacco? .....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use alcohol, cocaine or other drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you wearing contacts? .....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have or have you had any of the following?			Codeine .....	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	Angina .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions .....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection .....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems/Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem .....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>
				Yes	No
			8. Women Only:		
			a) Are you pregnant or think you may be pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>
			b) Are you nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>
			c) Are you taking birth control pills? .....	<input type="checkbox"/>	<input type="checkbox"/>

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**X**  
Signature of patient or parent if minor

## Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights were given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- \* Treatment (including direct or indirect treatment by other health care providers involved in my treatment);
- \* Obtaining payment from third party payers (e.g., my insurance company)
- \* The day-to-day health care operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or parent if minor