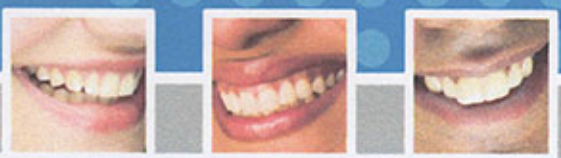
Bardstown Family Dentistry
810 Morton Avenue
Suite 200
Bardstown KY 40004-2549
(502)348-9944
tooth@bardstown.com



Welcome to our Practice

Chart #. _____
FOR OFFICE USE ONLY

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

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

In an emergency who should be notified? Please enter Name and Phone number:

Who may we thank for referring you to our office?

Payment is due at the time of service, as are co-pays and deductibles. How are you paying today? Thank you

☐ Check ☐ Cash ☐ Credit Card ☐ CareCredit

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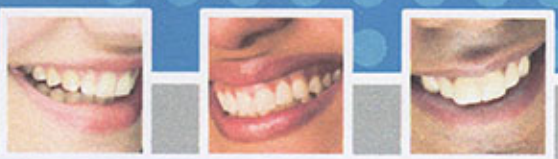

Responsible Party Information

Parent/Guardian Information:

This only needs to be filled out if insurance subscriber is other than patient, or if patient is under 18.

Relationship to patient

☐ Self ☐ Mother ☐ Father ☐ Other

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

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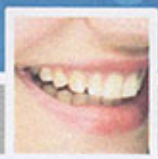
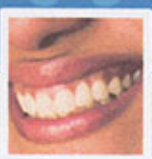
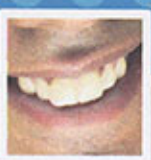

Medical History

- ☐ *Latex Allergy
- ☐ *Premed - Amox.
- ☐ *Premed - Clind.
- ☐ *Premed
- ☐ Allergic-Aspirin
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Val
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Codeine Allergy
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysemia
- ☐ Epilepsy
- ☐ Erythromycin Allergy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fever Blisters
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Local Anestheic
- ☐ Mental Disorders
- ☐ Methol Allergy
- ☐ Mitrol Valve Prolaps
- ☐ Morphine Allergy
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Penicillin Allergy
- ☐ Pregnancy
- ☐ PsychiatricTreatment
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

- ☐ Chemotherapy
- ☐ Headaches
- ☐ Surgical Implant
- ☐ Tobacco habit
- ☐ Have you ever been treated with medication for osteoporosis or bone cancer?
- ☐ Are you currently pregnant?

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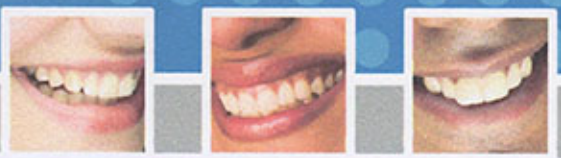

Are you allergic to any medicines? If so, please list.

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Describe any conditions, alerts, current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all current MEDICATIONS and REASON for the medication.

☐ By checking this box, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Previous Dentist name and how long have you been a patient there:

Date of most recent dental exam:

What is your immediate concern?

Response Date:

Bardstown Family Dentistry Authorization Form

Patient Name_____

I authorize Bardstown Family Dentistry to discuss my dental treatment, and/or payment information with the following person / people listed below. I understand that it is my responsibility to inform the office if this information should change.

_____

_____

_____

I authorize Bardstown Family Dentistry to discuss treatment regarding my child / children to the following person / people listed below.

_____

_____

_____

I authorize Bardstown Family Dentistry to leave messages on my home or cell phone. □ Yes □ No

Signature: _____ Date: _____