Print Email

Welcome to Dr. Leucht

PATIENT INFORMATION

Date _____

SS# _____

Patient Name _____

Address _____

City _____ State_____ Zip_____

How Long? _____ Rent ☐ Own ☐

E-mail _____

Sex ☐ M ☐ F Age_____

Birth Date_____

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation _____

Employer Name _____

Spouse's Name _____

Spouse's Birth Date_____

_____

Spouse's SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

Acknowledgment of Receipt of Notice of Privacy Policies

I, _____, have received a copy of Dr. Brett Leucht, Notice of Privacy Policies. I understand Dr. Brett Leucht may use my health care information and may disclose such information for treatment payment, and health care operations.

_____Printed Name

_____Signature & Date _____

DENTAL INSURANCE

Who is financially responsible for this account?

_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birth Date_____ SS#_____

Relationship to Patient _____

Insurance Co. _____

Group# _____

Insurance Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to

Name of insurance company(ies)

Dr. _____

all insurance benefits, if any, otherwise payable to me for services rendered.

Financial and Personal Health Information

I understand that I am financially responsible for all charges incurred during treatment. I further understand that any insurance contract is between my insurance carrier and myself and Dr. Brett Leucht is not part of that contract. As a courtesy to our valued patients we will submit your insurance forms initially. If problems occur with the insurance portion of your obligation, the balance in full will become due in 30 days. We will provide information to help you deal with your carrier. I understand that finance charges will begin 60 days from date of service if the balance is not paid in full. I authorize the use of my signature on all insurance submissions.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext_____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home Phone(_____) _____ Work Phone(_____) _____

HEALTH HISTORY UPDATE

To be updated at your future dental visits

Date of Visit	Changes to Health History/Medication	Detail Changes Initial
1. _____	Yes_____ No_____	_____
2. _____	Yes_____ No_____	_____
3. _____	Yes_____ No_____	_____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Cracking or popping jaw	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No
Fingernail Biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Grinding Teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth Breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic Treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal Treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

DENTAL HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Are you pregnant? ☐ Yes ☐ No	Congenital Heart Lesions ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No
AIDS/HIV ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Nervous Problems ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No
Arthritis, Rheumatism ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No
Artificial Heart Valves ☐ Yes ☐ No	Fainting or Dizziness ☐ Yes ☐ No	Respiratory Disease ☐ Yes ☐ No
Artificial Joints ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Shortness of Breath ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Headaches ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Back Problems ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Skin Rash ☐ Yes ☐ No
Bleeding abnormally with extractions or surgery ☐ Yes ☐ No	Heart Problems ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Hepatitis Type _____ ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Ulcer ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Circulatory Problems ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Other: _____
	Low Blood Pressure ☐ Yes ☐ No	

Current Physician: _____ Phone: _____

Address: _____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

Pharmacy Name _____

Phone (____) _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

Leucht Family Dentistry

4544 Taylorsville Road
Louisville, KY 40220
Financial Policy

Thank you for choosing us as your dental health provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. In order to keep our fees from rising dramatically and to minimize the expenses of billing and bookkeeping, the following financial policy will now be in effect for our office:

All patients must complete our patient information form and insurance form before seeing the doctor.

- Full payment is due at time of service.
- We accept cash, checks, Visa and MasterCard, American Express & Discover.
- We offer an extended payment plan with prior credit approval.

We will file all insurance claims for our patients as a **courtesy.** This does not transfer your financial obligation to your insurance company. We will bill you for any balance left after your insurance company pays us and all applicable write-offs have been taken. After 90 days your account balance is due in full even if your insurance has not paid.

Note:

1. A minimum payment is required depending upon your arrangement with us.

2. Your payment must be received by the 20th of the month. There may be a late payment fee assessed if payment is not received by the due date.

3. If your balance is not paid in full within 60 days a finance charge of .66% will be posted on your account each month thereafter. All parties are responsible for reasonable attorney's fees, upon default of payment, whether suit be brought or not.

4. A 24 hour notice is required when cancellation or rescheduling of an appointment becomes necessary. If you do not show or cancel at the last moment a charge of $35.00 will be applied to your account. If you arrive more than 15 minutes late, you will be rescheduled and charged for missed appointment. Broken appointment charges must be paid before we can reschedule. Please help us to serve you better by keeping scheduled appointments.

PLEASE UNDERSTAND THAT YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED IN OUR OFFICE

_____

Signature of Account Holder/Responsible Party **Date_____**

HIPAA Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purpose of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact: Sara Ernst 491-3323

Patients Consent

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

SSN: _____

I, _____ have read your Notice of Privacy Policies and I consent to your use of my PHI for the purpose of healthcare operations, treatment and payment activities.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

Signature:_____ Date:_____

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature to revoke authorization:_____ Date:_____

This information is intended as advisory in nature and should not be considered

The Federal HIPAA privacy compliance requirements are explained in this binder. When you develop your HIPAA compliance policy, incorporate whatever is necessary to address state law requirements as well.