PATIENT INFORMATION

DATE _____

NAME _____ SPOUSE'S NAME _____

ADDRESS _____ ZIP CODE _____

HOME PHONE (____) _____ BUSINESS PHONE (____) _____ CELL (____) _____

DATE OF BIRTH _____ SEX ____ SINGLE ____ MARRIED ____ SOCIAL SECURITY NO. _____ - _____ - _____

EMPLOYER _____ EMAIL _____

CLOSEST RELATIVE _____ PHONE (____) _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

DENTAL INSURANCE INFORMATION

Please give your dental insurance card to the front desk!

PRIMARY INSURANCE

INS. CO. NAME _____

INS. CO. ADDRESS _____

INS. CO. PHONE _____

INSURED NAME / ID _____

INS. GROUP # _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

EMPLOYEE DOB _____

SECONDARY INSURANCE

INS. CO. NAME _____

INS. CO. ADDRESS _____

INS. CO. PHONE _____

INSURED ID _____

INS. GROUP # _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

EMPLOYEE DOB _____

PATIENT'S RELATIONSHIP TO EMPLOYEE _____

I UNDERSTAND IT IS MY RESPONSIBILITY TO PAY ALL CHARGES, INCLUDING ANY DEDUCTIBLE, CO-INSURANCE, OR CHARGES NOT PAID FOR BY MY INSURANCE. IF THIS ACCOUNT IS ASSIGNED FOR COLLECTION TO ANY ATTORNEY AND/OR COLLECTION AGENCY, THE PREVAILING PARTY SHALL BE ENTITLED TO ALL EXPENSES AND COSTS OF COLLECTION, TOGETHER WITH INTEREST AT THE RATE OF EIGHTEEN PERCENT (18%) PER ANNUM ON THE ENTIRE DEBT (INCLUDING EXPENSES AND COSTS OF COLLECTION) FROM THE DATE THE ACCOUNT IS ASSIGNED FOR COLLECTION. TO THE EXTENT NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT, I AUTHORIZE DISCLOSURE OF PORTION OF MY DENTAL RECORD. I HEREBY ASSIGN ALL DENTAL INSURANCE BENEFITS TO: *KEVIN S. MIDKIFF, DDS, PC 20331 TIMBERLAKE ROAD, SUITE B LYNCHBURG, VIRGINIA 24502*. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

SIGNED _____ DATE _____

PAYMENT IS DUE AT THE TIME OF SERVICE

PATIENT HEALTH RECORD

DATE _____

NAME _____
(LAST) (FIRST) (INITIAL)

DATE OF BIRTH _____ SEX _____

MEDICAL HEALTH

NAME OF PRIMARY PHYSICIAN _____

HAVE YOU BEEN UNDER A PHYSICIAN'S CARE DURING THE PAST 2 YEARS? _____ FOR _____

HAVE YOU BEEN TREATED IN A HOSPITAL IN THE PAST 2 YEARS? _____ FOR _____

HAVE YOU EVER HAD MAJOR SURGERY? _____

IF FEMALE: ARE YOU TAKING HORMONES OR BIRTH CONTROL? _____ ARE YOU PREGNANT OR NURSING? _____

HAVE YOU EVER HAD A BLOOD TEST FOR HEPATITIS? _____ WERE YOU VACCINATED? _____

HAVE YOU HAD CANKERS OR COLD SORES ON YOUR LIPS, TONGUE, GUMS OR BODY? _____

ARE YOU NOW TAKING OR HAVE YOU TAKEN ANY PRESCRIPTION DRUGS, HERBS OR VITAMINS DURING THE PAST YEAR? LIST _____

HAVE YOU EVER HAD A REACTION OR RASH TO METALS? (EXAMPLE: JEWELRY) _____

ARE YOU ALLERGIC TO: ❑ PENICILLIN ❑ CODEINE ❑ LOCAL ANESTHETICS ❑ OTHER _____

_____

HAVE YOU HAD OR DO YOU NOW HAVE:

	yes	no		yes	no
AIDS	❑	❑	HEPATITIS	❑	❑
ABNORMAL BLOOD PRESSURE	❑	❑	HERPES	❑	❑
ALLERGIES	❑	❑	JAUNDICE	❑	❑
ANEMIA	❑	❑	KIDNEY DISEASE	❑	❑
ANGINA	❑	❑	LIVER DISEASE	❑	❑
ARTHRITIS	❑	❑	ORGAN TRANSPLANT	❑	❑
ARTIFICIAL HEART VALVES	❑	❑	PACEMAKER	❑	❑
ARTIFICIAL JOINTS	❑	❑	POLIO	❑	❑
ASTHMA	❑	❑	PROLONGED BLEEDING	❑	❑
CANCER	❑	❑	PROLONGED COUGH	❑	❑
CHEMOTHERAPY	❑	❑	PSYCHIATRIC TREATMENT	❑	❑
CONGENITAL HEART LESIONS	❑	❑	RADIATION THERAPY	❑	❑
DIABETES	❑	❑	RHEUMATIC FEVER	❑	❑
DRUG DEPENDENCY	❑	❑	SICKLE CELL ANEMIA	❑	❑
EPILEPSY	❑	❑	STROKE	❑	❑
FAINTING	❑	❑	THYROID DISEASE	❑	❑
GLAUCOMA	❑	❑	TUBERCULOSIS	❑	❑
HEART DISEASE	❑	❑	ULCERS	❑	❑
HEART MURMUR	❑	❑	VENEREAL DISEASE	❑	❑

HAVE YOU ANY DISEASE, CONDITION, OR PROBLEM NOT PREVIOUSLY LISTED? _____

_____

DENTAL HEALTH

WHEN WAS YOUR LAST DENTAL VISIT/CLEANING? _____

HOW OFTEN DID YOU SEE YOUR DENTIST? _____

ARE YOU HAVING ANY DENTAL PROBLEMS THAT REQUIRE IMMEDIATE ATTENTION? _____

DO ANY OF THE FOLLOWING CAUSE TOOTH DISCOMFORT? HOT _____ COLD _____ SWEETS _____ CHEWING _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ FLOSS? _____ WATER JET? _____

DO YOUR GUMS BLEED WHILE CLEANING? _____

DO YOUR GUMS EVER FEEL TENDER OF SWOLLEN? _____

HAVE YOU HAD PERIODONTAL TREATMENT? _____ WHEN? _____

DO YOU CLENCH OR GRIND YOUR TEETH? _____

DO YOUR JAWS EVER FEEL TIRED OR ACHE? _____ CLICK OR POP? _____

CAN YOU CHEW ON BOTH SIDES OF YOUR MOUTH? _____ COMFORTABLY? _____

DO YOU HAVE FREQUENT HEADACHES? _____ EARACHES? _____

HAVE YOU EVER HAD ORTHODONTIC TREATMENT (BRACES)? _____ WHEN? _____

DO YOU LOSE FILLINGS OR BREAK FILLINGS? _____

DO YOU USUALLY HAVE MANY CAVITIES? _____

DO YOU HAVE ANY LOOSE TEETH? _____ CRACKED OR BROKEN TEETH? _____

DO YOU HAVE ANY NOTICEABLE WEAR ON YOUR TEETH? _____ FOOD TRAPS _____

DO YOU HAVE ANY MISSING TEETH? _____ HAVE THEY BEEN REPLACED? _____

IF SO, HOW? FIXED BRIDGE _____ REMOVABLE PARTIAL _____ FULL DENTURE _____ DENTAL IMPLANT _____

ARE YOU COMFORTABLE WITH THE REPLACEMENT? _____ PLEASE DESCRIBE _____

_____

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR SMILE? _____

HAVE YOU EVER HAD ANY COSMETIC DENTISTRY DONE TO IMPROVE YOUR APPEARANCE? _____

IF YES, ARE YOU PLEASED WITH THE RESULT? _____ PLEASE COMMENT _____

_____

HAVE YOU EVER HAD AN UNPLEASANT DENTAL EXPERIENCE? _____

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT: _____

_____

_____

_____

_____

_____

SIGNATURE _____

Kevin S. Midkiff, D.D.S.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACROSS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY
THIS PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy that are described in this notice while it is in effect. This notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practice and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time, For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operation. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment t you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improved activities, reviewing the competence or qualifications of healthcare professions, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operation, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in affect. Unless you give us a written, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the patients rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment to your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of of your incapacity or emergency circumstances, we will disclose health information based on determination using professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-ray, or other similar forms of health information.

Kevin S. Midkiff, D.D.S.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***** you may refuse to sign this acknowledgment*****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
printed name

_____
signature

_____
date

For Office Use Only

We attempted to obtain written acknowledge of receipt of our notice of privacy practices, but acknowledgment could not be obtained because:

____ Individual refused to sign
____ communication barriers prohibited obtaining the acknowledgment
____ An Emergency situation prevented us from obtaining acknowledgment
____ Other (please specify)

_____

_____

_____

Kevin S. Midkiff, DDS, Family & Cosmetic Dentistry
20331 Timberlake Rd, Suite B
Lynchburg, VA 24502
(434)-239-8133

Written Financial Policy

Thank you for choosing Kevin S. Midkiff, DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

-Cash, Check, Visa, MasterCard, American Express, or Discover Card. We offer a 10% discount to patients with no insurance who pay for their treatment the day of.

-No Interest payment plans from Care Credit

- Allow you to pay over a period of time with NO INTEREST
- Convenient, low monthly payment plans also available
- No annual fees or pre-payment penalties

Please note:

If you have insurance, we will file with them first, and send you a bill for the remaining balance. We can always file estimates for any future work you need to have done, that way you know what your portion will be ahead of time.

If you do not have insurance, we require you to pay for any treatment at the time of service. We offer a 10% courtesy discount for anyone paying with cash or check.

If you have any questions please do not hesitate to ask the front desk, we are here to help.

_____ _____

Patient, parent, or guardian signature Date

_____ _____

Patient name (please print) Date

Records Release Form

Dr. Kevin Midkiff Family & Cosmetic Dentistry
434-239-8133
Fax: 434-239-8519
Email: drmidkiff@ident.com

Date_____

Records Transfer for _____ DOB _____

_____FMX _____ BWX _____PA's _____PANO _____ Perio Charting

Last oral Evaluation_____

Last Prophylaxis _____

*If you have any questions regarding treatment on this patients care while in our office, Please feel free to contact us. *

*please send the x-rays to the email above *

Signature:

Patient or Guardian _____ Date_____

☆ Minor Consent form ☆

Dr. Kevin S. Midkiff
20331 Timberlake Road, Suite B
Lynchburg, VA 24502
(434)-239-8133

I, the undersigned parent or legal guardian of (minors full name) _____ who is a minor, do hereby authorize and consent to dental treatment from Dr. Kevin Midkiff.

For occasions when you may not accompany your child, **list individuals who may give us consent to treat your child.**

1. _____

2. _____

3. _____

4. _____

5. _____

_____
Parent/Legal Guardian Printed Name and Relationship

_____
Parent/Legal Guardian Signature Date

_____
Witness Date

*****Verbal Consent*****

Consent given by _____Relationship_____

Date_____Time_____Initials_____