

ABELL GENERAL DENTISTRY P.S.C.  
DR. FRANCIS D. ABELL & DR. DANIEL F. ABELL

---

Name (Last,First,Middle): \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License#: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Phone: Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_  
Employer: \_\_\_\_\_ How long held: \_\_\_\_\_  
Name of Spouse (or parent): \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Driver's License#: \_\_\_\_\_ Contact Phone#: \_\_\_\_\_  
Person Responsible for Paying Account: \_\_\_\_\_  
How did you hear about our office?  TV  Radio  Newspaper/Magazine  Billboard  
 Internet  Family/Friend/Referral: \_\_\_\_\_

We will be happy to file your insurance for you. Deductibles and co-pays are due at time of service. Payment is due in full if no insurance is involved. We do except Mastercard, Visa, or Discover for your convenience.

**PRIMARY DENTAL INSURANCE COVERAGE**

Subscriber Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
DOB: \_\_\_\_\_ Address: \_\_\_\_\_  
Insurance Co: \_\_\_\_\_ Group#: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE COVERAGE**

Subscriber Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
DOB: \_\_\_\_\_ Address: \_\_\_\_\_  
Insurance Co: \_\_\_\_\_ Group#: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Please Read and Sign the Following Responsibility and Consent Statement**

To the best of my knowledge the above information is complete and correct. I understand that I am responsible for any financial obligation incurred for the services provided. I hereby authorize and request the performance of dental services for myself (or child - if minor) so designated above, and give my consent to any advisable and necessary dental procedures, medication, anesthetics, or analgesics to be administered by the attending dentist, or by his supervised staff for dental treatment.

I agree, in order for you to service my account, notify me of information pertaining to my account, or for purpose of collection, you may contact me by telephone at any number provided by me, including wireless telephone numbers.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Dental History

Former Dentist: \_\_\_\_\_ City/State: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

Do you have dental anxiety? \_\_\_ Yes \_\_\_ No

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

Bad Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Gums	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loose teeth or broken fillings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chew on one side of the mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food collection between teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gums swollen or tender	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sores or growths in your mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jaw pain or tiredness	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FRANCIS D. ABELL, D.M.D.  
DANIEL F. ABELL, D.M.D.  
4975 Alben Barkley Dr. Ste 3  
PADUCAH, KENTUCKY 42001  
(270) 554-3031

## Notice of Privacy Practices Patient Acknowledgement

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_

## Appointment Change Policy

Abell General Dentistry requires a 24-hour notice for any appointment change. If a 24-hour notice is not received, there will be a \$25.00 charge. This charge is not a covered benefit by your insurance company and will be your responsibility. Abell General Dentistry will not be able to re-schedule any dental appointments until this charge is paid.

I, \_\_\_\_\_, have reviewed and understand Abell General Dentistry's policy for appointment change without a 24-hour notice.

\_\_\_\_\_  
Patient's Signature or Parent/Guardian's Signature

\_\_\_\_\_  
Date

## Returned Check Policy

There will be a \$25.00 charge for each check returned to us due to insufficient funds. No appointments will be made until this fee, as well as the outstanding balance, has been paid.

I, \_\_\_\_\_, have reviewed and understand Abell General Dentistry's returned check policy.

\_\_\_\_\_  
Patient's Signature or Parent/Guardian's Signature

\_\_\_\_\_  
Date