Dear [FIRST NAME],

Welcome to our dental family. We appreciate the confidence and trust you have placed in us, and we look forward to getting to know you personally.

We will provide you with the highest quality preventative and restorative dentistry, always striving to offer state of the art dental care. We provide a complete, thorough examination on your first visit, gathering all pertinent information for your dental healthcare. Our doctors will review all the information, establishing a diagnosis and life-long care program that will assist you in maintaining and maximizing your personal well-being.

Our goal is for you to keep all your teeth for all your life with maximum comfort, function, health and aesthetics. Within your care program, we will present you with options that will enable you to attain and maintain your dental health within your personal time frame and resources.

We believe our fees are in line with our levels of education, experience and dental expertise. We have specially trained staff members dedicated to assisting you with your financial arrangements and all of your insurance needs. We understand and appreciate your financial concerns and will work hard to make your treatment affordable.

We will make every effort to maintain our schedule and yours. Please assist us by calling 24 hours in advance if unforeseeable events cause you to miss your reserved appointment time.

We welcome you to the Catron & Keally Dental family! Individually and collectively, we pledge to provide you ultimate effort, comfort and understanding in providing preventative dental health and education, always maintaining the highest quality restorative care. Do not hesitate to express any questions or concerns you may have throughout your care with us.

With best regards,

Carson P. Keally, DMD,
William R. Catron, DMD,
and the Catron & Keally Dental Team

Catron & Keally Dentistry
140 Hubbard Road
Winchester, KY 40391
859.744.0200

Date:

First Name: ____________________________ **Last Name**_______________________________ **Middle Initial**_____
Preferred Name: _____________________ **Email:**
____
Phone Number: _____________________ **Work Phone:** ____________________
Employer: ________________________________ **Occupation:**________________________________

What is the BEST way to reach you? Cell Phone Home Phone Work Phone E-mail Text

Address:
____
street city state zip
Birth date: __________________ **Social Security #:** _________________________

Sex: Male Female **Marital Status:** Married Single Divorced Widowed

We are glad you are here today! Please share how you heard about us: ___________________________

Emergency Contact Information **Name**: __________________________ **Phone:** _________________________

Responsible party (if someone other than patient)
First Name: _____________________________ **Last Name**_______________________________ **Middle Initial**_____
Address:
____
street city state zip
Home Phone: ___________________ **Cell Phone**: _____________________ **Work Phone:** ______________________
Birth date: __________________ **Social Security #:** _________________________

Primary Dental Insurance Information
Name of Insured: _________________________________ **Relationship to insured:** self spouse child other
Insured Social Security #: ___________________________ **Insured birth date:** _______________
Employer: _______________________________________ **Dental Insurance Co:** ___________________________
Insurance ID #____________________________________ **G r o u p #** ____________________________________

Secondary Dental Insurance Information
Name of Insured: _________________________________ **Relationship to insured:** self spouse child other
Insured Social Security #: ___________________________ **Insured birth date:** _______________
Employer: _______________________________________ **Dental Insurance Co:** ___________________________
Insurance ID #____________________________________ **G r o u p #** ____________________________________

We will gladly file your insurance as a courtesy and will do our best to provide you accurate estimates of your portion. In the event that your account is unpaid we reserve the right to forward your account information to a collection agency. Without a 48 hour notice we reserve the right to charge for cancelled and missed appointments. As an office our goal is to collect deductibles and patient portions in a timely manner. Multiple payment options are available; do not hesitate to discuss your options with our front desk.

Authorization for Treatment
I authorize the dentist to perform diagnostic procedures and treatment that may be necessary for proper dental care.

Signature____ **Date**___________________________

CATRON CK KEALLY DENTISTRY

HEALTH HISTORY

Name ______________________________ Date ____________________

Date of last health care exam: ____________ What was this exam for? ____________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ______________________________

Are you currently receiving care? No Yes If yes, nature of care: ____________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1. ____________ 2. ____________
3. ____________ 4. ____________
5. ____________ 6. ____________
7. ____________ 8. ____________

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. ____________ 2. ____________
3. ____________ 4. ____________
5. ____________ 6. ____________

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Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
Have you ever received a diagnosis of "high blood pressure"?
What is your normal blood pressure? S /D Today: ___________________/__________

Are you allergic or have you had a reaction to:

a. Local anesthetics ……………………………………………………….. No Yes
b. Penicillin or other antibiotics ………………………………………… No Yes
c. Aspirin, Ibuprofen or Tylenol …..…………………………………… No Yes
d. Codeine, Valium® or other sedatives…………………………………… No Yes
e. Latex or Metals
f. Other (please specify)____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none slight moderate high*			

DOCTOR'S USE ONLY
Comments on patient interview concerning medical history:
____
____

Significant findings from questionnaire or oral interview:
____
____

Dental management considerations:
____
____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

________________________ ________________________ ______________
Patient (Print Name) *Patient Signature* *Date*

________________________ ________________________ ______________
Doctor (Print Name) *Doctor Signature* *Date*

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Catron & Keally Dentistry

Dental History

Name: ________________________
Date: _________________________

Do you have any immediate dental concerns? ____________________________________
____

Previous Dentist: ____

Approximate Date of Last Dental visit: ________________ Dental X-rays: ______________

How would you rate your smile on a scale from 1 to 5, with 5 being the best? ______________

How often do you brush? _________________ Floss? ____________________________

Please circle Y or N, if Yes please fill in blank with details

Y N Is there anything you would like to change about your teeth/smile? ________________

Y N Do you wish your teeth were whiter? ______________________________________

Y N Have you ever had orthodontic treatment (braces)? ___________________________

Y N Are you currently in any dental pain? ______________________________________

Y N Is any part of your mouth, or certain teeth sensitive to temperature change? __________

Y N Do you have a burning sensation in your mouth? _____________________________

Y N Do you have any swelling in your mouth? ___________________________________

Y N Do your gums bleed when you brush/floss? __________________________________

Y N Have you ever been told you clench/grind your teeth? ___________________________

Y N Do you ever notice that you are clenching or grinding your teeth? _________________

Y N Do you ever wake up in the morning with sore jaw muscles? _____________________

Y N Do you suffer “tension”/stress headaches? ___________ How often? ______________

Y N Do you have trouble opening widely? ______________________________________

Y N Have you ever had an unpleasant experience at the dentist? _____________________

Y N Have you ever had an adverse reaction to dental anesthetic? _____________________

Y N Do you believe you have active dental disease? ______________________________

Y N Are you interested in learning to control your dental disease and prevent future disease?

Y N Do you prefer to use Nitrous Oxide (laughing gas) when having treatment completed?

Our goal is to provide you the personalized and exceptional care that you deserve. Please use this remaining space to alert us to any other concerns or questions you may have about your teeth, treatment or dental health: ____

____

Photography Model Release

I, ______________________________, hereby authorize Catron & Keally Dentistry to take photographs, slides and/or video of my face, jaws and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my care and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines and television), and professional publications (dental magazines and journals). These images may include full face portraits and close-up views of teeth.

Furthermore, I understand that if the photographs, slides and/or video are used in any publications or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise for use of these photographs.

____ ______________

Signature Date

smileky.com
859.744.0200

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________________, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.
- I understand that the office staff will be happy to answer any questions that I may have.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

OR

I, ______________________________________, hereby acknowledge that I was offered a copy of this office's *Notice of Privacy Practices* and declined to retain my copy. I am aware that I can retain a copy of the *Notice of Privacy Practices* from this office at any time.

I also understand that if I have any questions or complaints, I may contact the office at 859.744.0200.

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Once again, for more information please contact our office.

Patient Information

Signature: ____ Date: _____/_____/_____

Print Name: ____

Relationship to Patient: ____

For Office Use Only

A good-faith attempt was made to receive acknowledgement of our *Notice of Privacy Practice* from ______________________________________. Despite our efforts we were unable to obtain a signature for the following reason: ____.

Acknowledgement was attempted by: _________________________ Date: _____/_____/_____

William R. Catron, DMD
Carson P. Keally, DMD