James Ransdell Dental Care, PSC

~~ransdelldentistry@hotmail.com~~

3600 Taylor Blvd.
Louisville, KY 40215
502-367-1536
www.southlouisvillesmiles.com

4819 Taylorsville Rd.
Taylorsville, KY 40071
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www.elkcreekdentalcare.com

PATIENT INFORMATION

Name:_____ **SS#**____/____/____ **DOB:**____/___/___ **Age:**____

Address:_____
Street City State Zip

Sex: M/F **Marital Status:** S/M/D/W **Employer:**_____ **Pharmacy:**_____

Home Phone:_____ **Work Phone:** _____ **Cell Phone:**_____

Email:_____ **Emergency Contact:**_____
(Name/Phone #)

Person responsible for this account:_____ **SS#**____/____/____
(leave blank if same as above)

Dental Insurance Company (ifapplicable)_____ **Group#**_____

Policy Holder:_____ SS#____/____/____ DOB:___/___/___

Secondary Dental Insurance _____ Group# _____

Policy Holder:_____ SS#____/____/____ DOB:___/___/___

Who may we thank for referring you to our office?_____

Financial Arrangements: Payment is expected in full at each appointment unless prior payment arrangements have been made. For your convenience we offer the following payment methods. Cash, Check, MasterCard, Visa, Discover & CareCredit

Please read and sign: Authorization and Release

I have reviewed the following treatment plan. I authorize release of any information relating to me or my responsible parties claim. **I understand that I am responsible for all costs of dental treatment regardless of insurance coverage, and that most dental insurance plans do not cover all cost of treatment.** I hereby authorize insurance payment directly to the dentist, otherwise payable to me. I realize that payment in full is expected at the time of treatment unless other written arrangements have been made. Accounts with an unpaid balance over 60 days will be charged up to 1.5% of the balance due per month. **Patient is responsible for unpaid balances after 60 days**. In the case of nonpayment on this account, after 120 days, I agree that the account will be referred to a collection agency and credit bureau for report and collection. I further agree to pay collection costs and reasonable attorney's fees incurred in attempting to collect on this amount or any future outstanding account balance.

Signed:_____ Date:____/____/____

MEDICAL/DENTAL HISTORY

1. Have you been seen by a physician in the last year? If yes, reason:_____
2. Are you presently under medical care? If yes, reason:_____
3. Please list any prescription, OTC, street drugs or natural supplements you have taken in the last 3 days?

_____

_____

4. Have you ever had prolonged illness or hospitalization? Y / N If yes, explain:_____
5. Have you ever had any of the following diseases?
   - Jaundice or Hepatitis (yellow skin eyes): Yes/ No/ DK
   - Rheumatic fever: Yes/ No/ DK
   - Kidney trouble: Yes/ No/ DK
   - Epilepsy or seizures: Yes/ No/ DK
   - Diabetes: Yes/ No/ DK
   - High Blood Pressure: Yes/ No/ DK
   - Low Blood Pressure: Yes/ No/ DK
   - Venereal disease: Yes/ No/ DK
   - Thyroid Disease: Yes/ No/ DK
   - Tuberculosis: Yes/ No/ DK
   - HIV: Yes/ No/ DK
6. Do you use tobacco? Y/N If yes, which type, how much and how often?_____
7. Have you lost weight without dieting in the last few months? Yes/ No/ DK
8. Have you ever been sick from a shot for dental treatment? Yes/ No/ DK
9. Have you ever had serious bleeding after a tooth extraction? Yes/ No/ DK
10. Have you or a relative had a bleeding problem? Yes/ No/ DK
11. Are you allergic to any foods, clothing, animals, etc? If yes, please list:_____
12. Do any of the following medications make you ill or cause an allergy? Aspirin: Yes/ No/ DK
    Penicillin or antibiotics: Yes/ No/ DK Sulfa Drugs: Yes/ No/ DK Barbituates: Yes/ No/ DK
    Local anesthetics (Novacaine) Yes/ No/ DK Other medicines: Yes/ No/ DK If yes, please list:_____
13. Have you ever been told by a physician you have a heart murmur? Yes/ No/ DK
14. Do you have chest pains upon exertion? Yes/ No/ DK
15. Have you had artificial joint surgery? Yes/ No/ DK Have you been told you need pre-medication? Yes/ No/ DK
16. Do you have painful or swollen joints: Yes/ No/ DK
17. Do you have a blood disorder? Yes/ No/ DK
18. Are you pregnant? Yes/ No/ DK If yes, expected delivery date?_____
19. Any other information concerning your medical/dental health that you feel the dentist should be aware of?
    _____
20. Primary Care Physician Name:_____ Phone#_____
21. What is your primary dental problem at this time?_____
22. Who was your previous dentist and when was your last visit?_____
23. Explain any previous medical problems you may have had when visiting a dentist in the past?
    _____

Patient (or parent/guardian) Signature:_____ Date: ___/___/____

Dr. James E. Ransdell's Dental Office

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

I have received/read a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

TRUTH IN LENDING
EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES

INTEREST RATES AND INTEREST CHARGES	
Annual Percentage Rate (APR) for Purchases	**8.00%**
Paying Interest	A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown.
Minimum Interest Charge	**If you are charged interest, the charge will be no less than $1.00**

FEES	
Late Charge	**$1.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $5.00**
Non-Sufficient Funds (NSF) Fee	**$25.00 per payment**

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights. In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

_____
Dental Entity Name

_____ _____
Signature Date

_____ _____
Account Name Address

A photocopy of this document may act as an original

Form 05304KY (7-1-17)

SMILE EVALUATION

Please fill out this information so we can help you obtain the smile you've always wanted!!

1. How would you rate your smile? (1-10)_____

2. How often do you: Brush your teeth? _____times per day/week

   Floss? _____ times per day/week

   Use Fluoride? _____ times per day/week

3. Do you like the color the color of your teeth? (1-10)_____

4. Do you have spaces you don't like? Yes/ No

5. Do you like the general appearance of your teeth? Yes/ No
   If no, please explain:_____

6. Do you have teeth that are chipped? Protruding? Hidden?

7. Are there old fillings/dental work that you don't like looking at? No. Yes- please

   explain:_____

8. Do you have trouble chewing? No. Yes- explain_____

9. Do you have trouble with jaw pain (TMJ)? No. Yes-explain_____

10. Do you snore? No/ Yes

11. Do you grind your teeth? No/ Yes

12. Do your gums bleed? No/ Yes

13. Have you noticed constant bad breath? No/ Yes

14. Have you ever been instructed in the prevention of decay or in the care of your gums?
    Yes/ No

Name_____
Address_____
_____

Berlin Sleep Questionnaire

Instructions: Complete evaluation

SLEEP EVALUATION

1. Complete the following:
   height _____ age _____
   weight _____ male/female _____

CATEGORY 1

2. Do you snore?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

If you snore:

3. Your snoring is?
   - ☐ Slightly louder than breathing
   - ☐ As loud as talking
   - ☐ Louder than talking
   - ☐ Very loud...can be heard in adjacent rooms

4. How often do you snore?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

5. Has your snoring ever bothered other people?
   - ☐ Yes
   - ☐ No

6. Has anyone noticed that you quit breathing during your sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

CATEGORY 2

7. How often do you feel tired or fatigued after your sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

8. During your wake time, do you feel tired, fatigued or not wake up to par?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 time a month
   - ☐ Never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ Yes
   - ☐ No

   If yes, how often does it occur?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

CATEGORY 3

10. Do you have high blood pressure?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

BMI =

Scoring Questions:	Any answer within highlighted box outline is a positive response	
Scoring Categories:	Category 1 is positive with 2 or more positive responses to questions 2-6	☐
	Category 2 is positive with 2 or more positive responses to questions 7-9	☐
	Category 3 is positive with 1 or more positive responses and/or a BMI>30	☐
Final Results:	2 or more categories indicate a high likelihood of sleep disordered breathing	