Dr. L. Keith Woody DMD

325 Broadway Paintsville, KY 41240 (606.789.9092)
102 N. Lock Ave. Louisa, KY 41230 (606.638.9094)

Email: https://www.woodydentaloffice.com

Todays' Date_____

PATIENT INFORMATION

Name_____

Address_____

_____

Home _____ Cell _____

Email _____

☐ Female ☐ Male

DOB _____ SS# _____

Primary Physician Name_____

Phone_____

Emergency Contact _____

Phone _____

INSURANCE - * PLEASE PROVIDE CARD and PHOTO ID TO RECEPTIONIST

Primary Ins _____

Subscriber Name _____

DOB _____

ID# _____ Group # _____

Employer _____

Secondary Ins

Subscriber Name _____

DOB _____

ID # _____ Group # _____

TREATMENT AND PAYMENT AUTHORIZATION STATEMENT (SIGN & DATE)

I understand I am fully responsible for all costs of dental treatment. I hereby authorize my doctor to act as my agent and release all necessary information required by my insurance carrier and for all insurance payment to directly go to the doctor. I hereby authorize the doctor to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history form is correct to the best of my knowledge and it is my responsibility to inform this office of any changes.

Signature_____

IF PATIENT IS UNDER 18

Responsible Party _____ Relation to Patient _____

MEDICAL INFORMATION- check all that apply

____Reaction to any dental treatment

____Taking Aspirin or blood thinner _____

____Bone loss medications

____Steroid/cortisone therapy in the past 2 years

____Allergic reaction to latex

____Allergic reaction to any metals such as amalgam fillings

____Pregnant/ Due Date: _____ Nursing_____

List all medicines you are allergic to

1. _____
2. _____
3. _____
4. _____

____I am not allergic to any medicine to my knowledge

List all medications you're currently taking

_____

Do you have a history of :

___Rheumatic fever	___Venereal Disease	___Arthritis
___Heart Disease/Problems	___HIV/AIDs	___Sinus Problems
___Pacemaker/Difibulator	___Blood Transfusion	___Cancer Type: _____
___High Blood Pressure	___Excessive Bleeding	___Artificial Joints _____
___Low Blood Pressure	___Liver Disease	___Tobacco Use _____Vape Use
___Diabetes	___Kidney Disease	___Drug Addiction
___Stroke	___Dialysis	___Alcoholism
___Lung Disease/Problems	___Thyroid Problems	___Psychiatric Care
___Asthma	___Epilepsy or Seizures	___Teeth Grinding
___Allergies/Hives	___Stomach Problems	___TMJ (pain in jaw joint)

Other Medical information that could affect your dental care: _____

Patient's Signature _____Date_____

Dentist Signature _____Date_____

Patient Acknowledgement and Signature

_____ ***Consent for Care and Treatment***

I, the undersigned, hereby agree and give my consent for **L. Keith Woody D.M.D.,** to furnish care and treatment considered necessary and proper in treating my condition.

_____ ***Authorization for Signature on File and Release of Information***

I, the undersigned, hereby agree and give my consent for **L. Keith Woody D.M.D** to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorized the release of any information relating to my health care claims.

_____ ***Authorization for Assignment of Benefits***

I, the undersigned, hereby assign all insurance benefits, to which I am entitled, to, and I shall be financially responsible for any unpaid balance. In the event payment is made directly me for serviced rendered by this office, I recognize the obligation to promptly remit payment to **L. Keith Woody D.M.D**. I hereby authorize and instruct my insurance company to pay by check and mail directly to **L. Keith Woody D.M.D.**

_____ ***Financial Responsibility***

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsibility for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. Should my balance extend beyond 90 days with no attempt to may payment, I understand that my balance will be subject to a finance charge for which I am financially responsible.

_____ ***Cancellation Guidelines***

We have reserved a specific time for you with our providers. If you cannot keep your scheduled appointment, please be sure to notify us within two business days. If we are not given ample notification for a cancellation or you do not make it to your appointment, you may be subject to being dismissed as a patient from this practice.

_____ ***Reminder Message***

I, the undersigned, hereby authorize ***L. Keith Woody D.M.D /Office*** to call my phone with appointment reminders. It is my responsibility to keep the office updated with the correct number that I can always be contacted. I understand my appointment will be rescheduled if I do not confirm.

_____ ***HIPPA***

I, the undersigned, understand that my patient data and privacy rights are outlined according to the HIPPA Laws.

I have read & fully understood the above information, and hereby agree to comply as outlined:

_____

Patient Signature **Date**