Aesthetic Dental Center of Kentucky

347 W. Lincoln Tr. #1 • Radcliff, KY 40160 (270)351-3505

Date Completed: * _____

EMAIL ADDRESS: *

_____

_____

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Person/Persons to contact in case of EMERGENCY:

_____

_____

Please list all medications you are currently taking: *

_____

_____

_____

_____

Is there ANY chance that you are pregnant? Due Date: _____

* ○ Yes ○ No

Are you NURSING? * ○ Yes ○ No

Are you ALLERGIC PENICILLIN or any medication related to Penicillin?

○ Yes ○ No

IF "YES", provide a detailed list of medicines that you are allergic to:

☐ Penicillin ☐ Amoxicillin

☐ Clindamycin ☐ Other: _____

_____

_____

_____

Please list any "OTHER" allergies you may have:

_____

_____

Are you allergic to LATEX?

* ○ Yes ○ No

Do you have any history of ANY surgeries General and/or Cosmetic?

* ○ Yes ○ No

LIST of ALL SURGERIES: *

_____

_____

_____

_____

Please check ANY of the following that you CURRENTLY HAVE or HAVE HAD in the past:

*

☐ NONE
☐ Breast Implants
☐ Back/Neck Problems
☐ Diabetes
☐ HIV
☐ Seizures
☐ Stroke
☐ Thyroid Disease
☐ Tobacco Use
☐ Artificial joints
☐ Glaucoma
☐ Kidney Disease
☐ Osteoporosis
☐ Other: _____

OTHER not listed: *

_____

_____

_____

_____

HISTORY OF ANY OF THE FOLLOWING:

BLOOD DISEASE/DISORDERS

HEART ISSUES (ANY history of heart problems should be "checked")

*

☐ NONE
☐ Anemia
☐ Hemophilia
☐ Sickle Cell Anemia Other: _____
☐ CANCER HISTORY
☐ Cancer Type: _____
☐ Chemotherapy Treatment
☐ Radiation Treatment (circle one):
☐ Other Treatment not listed: _____
☐ HEART HISTORY
☐ Artificial Heart Valve
☐ Heart Attack
☐ Pacemaker
☐ HBP
☐ Other: _____
☐ LIVER HISTORY:
☐ Hepatitis: A B C
☐ Other: _____
☐ LUNG HISTORY
☐ Asthma
☐ C.O.P.D
☐ Tuberculosis
☐ Other: _____

*

_____
_____
_____
_____
_____

I ACKNOWLEDGE
I have provided correct medical information and do hereby give consent to any necessary treatment, medications or anesthetics to be administered by the attending dentist and staff for diagnostic purposes and/or dental treatment. Furthermore, I will not hold the Dentist or his staff responsible for any errors or omissions that I have made in the completion of this form. I have read and AGREE to the FINANCIAL procedures in this office AND acknowledge: A) That the ESTIMATED PATIENT amount listed on my treatment plan is an estimate ONLY and fees are expected to be paid on the date of service. B) Any and all services not paid by the insurance company is my financial responsibility. C) If my account is secured with a credit card or financing, I authorize any past due amounts to be charged to my credit

card/finance acct. D) If paying with check, I authorize electronic transfer(s) of funds from my checking/savings/other account(s). D) I grant my permission to the office and it's assignee's to contact me at my place of employment to discuss treatment and financial concerns. F) I authorize the use of my signature below on any and all insurance submissions associated with this office and I authorize my insurance company to pay Dr. Philip Cornette, III directly for any and all insurance benefits otherwise payable to me for services rendered. G) I authorize Dr. Philip Cornette, III and staff to release any and all information necessary; electronically (i.e., email, fax, cellular transmission of data) or otherwise, to facilitate my treatment/care with another dental provider/specalist/office/facility and/or secure payment of benefits for services rendered.

I ACKNOWLEDGE
If you need to cancel your appointment with us we require at least 24 hours notice. Cancellations will not be accepted via our voicemail or texting platform. IF 24 hours notice is not given, we reserve the right to charge you a $50 BROKEN APPOINTMENT FEE, PER PATIENT. We also reservce the right to not schedule any future appointments for you and discharge you as a patient.

Signature _____ **Date** _____

Response Date: _____