MIDWAY FAMILY
DENTAL

CONTACTUS@MIDWAYKYFAMILYDENTAL.NET

(859)618-6311

128 E. MAIN ST
MIDWAY, KY 40347

We are a general dental office that offers services such as:

- Exams
- Cavity Risk Assessment
- Periodontal Disease Risk Assessment
- Cleanings
- Gum Treatment
- Bacterial Replacement Therapy
- Ozone therapy
- Fillings
- Crowns
- Bridges
- Dentures
- Partial Dentures
- Veneers
- Whitening
- Invisalign
- Implant Restorations
- Sports Guards
- Night Guards
- Sleep Apnea Risk Assessment
- Extractions
- Oral Cancer Screenings
- Oral Bacterial Analysis
- Root Canal Therapy
- Safe amalgam removal

WELCOME

Welcome to the Midway Dental Family! We are thrilled to be serving you. I'd like to take a moment to share a little about who we are, what we believe and what sets us apart from other dental offices.

Our Mission

It is our mission at Midway Family Dental to provide everyone the opportunity to better health by offering the highest quality, minimally invasive dental care available in a safe environment, free from judgement.

We are working toward this mission in several ways:

Quality Dental Care

In today's dental market, you get what you pay for. And our office is dedicated to providing high-quality dental care by using the best materials for your dental work. We are a mercury-free office, and the filling material we use is non-toxic. We also use local labs for crowns and dentures so that your work can be more customized to you! Our team is dedicated to learning and staying up to date on the latest and best dental treatments available.

Minimally Invasive Treatment

This means we want to do whatever we can to save your natural tooth! It is our philosophy that nothing we make or replace will ever be as good as your original tooth structure, so we will do everything we can to preserve it.

Total Health & Wellness

Your oral health plays an important role in your overall health. We want to talk to you about all aspects of health to see if something in your mouth could be contributing to the rest of your body. We will treat you as a whole person…not just a mouth and teeth.

Prevention & Early Detection

We really care about preventing disease, not just treating it. This sets us apart from many offices who are there to treat the problem but not thoroughly assessing and preventing diseases in the first place. During your initial comprehensive exam, we evaluate the entire head and neck region, looking for signs of many diseases such as oral cancer, cavities, gum disease, sleep apnea, etc. We also partner with you to give you the proper tools needed to prevent such diseases from occurring.

A Great Dental Experience

We are working to make your dental visit as comfortable and pleasant as possible. You will see and feel the difference when you step inside. We have a warm, inviting front lobby and TV's with noise cancelling headphones in each room for an enjoyable visit. We also offer Nitrous Oxide (laughing gas) for those who are a little nervous about having treatment done.

Our Promise To You

We are so glad you chose our family to take care of you and your family. We promise to go the extra mile to give you the best dental experience possible.

"Effort is like toothpaste, you can always squeeze out just a little bit more!"

Patient Information Form

PART I: PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ Preferred Name: _____
Gender: _____ Marital Status: _____ Birthdate: _____
Home #: _____ Cell #: _____ Work #: _____
Email: _____ Permission to text: ___ Permission to email: ___
Address: _____ P.O. Box _____ City: _____ ST: _____ Zip: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Who can we thank for referring you? _____

PART II: DENTAL BENEFITS INFORMATION

Subscriber Information:
Name:_____ Relationship to Patient: _____ Birthdate: _____
SSN: _____ Address: _____ City/State/Zip: _____

Insurance Information:
Insurance Company: _____ Policy ID: _____ Group Name/Number: _____

ASSIGNMENT AND RELEASE
I certify that I, and any dependent(s) have insurance coverage with _____ and assign directly to the dentist all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. the above-named dentist may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ Date: _____
Signature of Patient, Parent, Guardian, or Representative

PART III: DENTAL CONCERNS

Please check all that you are concerned about or currently have.

Focus & Overall Objective
__ Comprehensive Evaluation
__ Checkup/hygiene appointment
__ Focused Exam (specific tooth)
__ Fear of dentist

Teeth Cleaning & Gum Disease
__ Bad breath
__ Worried about gum disease
__ Loose teeth
__ Bleeding gums
__ History of gum disease
__ History of a deep cleaning
__ Keeping my teeth is important
__ Get regular cleanings
__ Dry mouth

Teeth & Fillings
__ Broken teeth or fillings
__ Sensitive teeth
__ Toothache
__ Dark fillings
__ Tooth decay
__ Missing teeth
__ Replacing missing teeth
__ Interested in dental implants

Biologic
__ Mercury Fillings (safe removal)
__ Ozone in dentistry
__ BPA-free fillings
__ Biologic restorations
__ Concerned about root canal
__ Possible cavitations

Jaw/Bite/Orthodontics
__ Jaw joint clicking/popping
__ Pain in jaw, face, or neck
__ Frequent headaches
__ Teeth wearing down
__ Clenching
__ Grinding
__ Wearing a night-guard
__ Need an occlusal guard

Sleep Issues
__ Snoring
__ History of sleep apnea
__ Daytime tiredness
__ History of sleep apnea
__ Hate/can't wear CPAP

Cosmetic
__ Want to improve smile
__ Dark/stained teeth
__ Want straighter teeth
__ Want whiter smile
__ Space/gaps between teeth
__ Dark lines around crowns

Dentures
__ Need new dentures
__ Don't like look of dentures
__ Current dentures don't fit
__ Can't chew with current dentures
__ Change in face (collapsed or wrinkles)

Patient Health History Form

PART IV: HEALTH HISTORY

Please check all that you currently or have a history of having.

Cardiovascular
__ Heart murmur
__ Damaged heart valve
__ Prosthetic heart valve
__ Heart stent of angioplasty
__ Heart attack
__ Infective endocarditis
__ Angina, chest pain
__ Congestive heart failure
__ Peripheral artery disease
__ Swollen ankles
__ Bleeding/clotting problems
__ High blood pressure
__ High cholesterol
__ Irregular or rapid heart beat
__ Heart pacemaker
__ Congenital heart disease
__ None of the above

Endocrine Disorders
__ Thyroid Problems
__ Pituitary or adrenal problems
__ Insuline Resistant/ Pre-diabetes
__ Diabetes - Type I
__ Diabetes - Type 2
__ Renal/kidney disease
__ Dialysis
__ None of the above

Lungs
__ COPD
__ Asthma
__ Tuberculosis
__ Obstructive Sleep Apnea
__ None of the above

Liver & GI
__ Hepatitis
__ Fatty liver disease (cirrhosis)
__ Peptic ulcer disease
__ Gastric Reflux (GERD)
__ IBS
__ Colitis
__ None of the above

Cancer
__ Cancer or tumor
__ Chemotherapy
__ Radiation therapy
__ HPV Positive (human papilloma)
__ Excessive sun exposure
__ None of the above

Gender Specific
__ Pregnant or planning
__ Nursing Mother
__ Birth control pills
__ Erectile Dysfunction
__None of the above

Bone
__ Osteopenia
__ Osteoporosis
__ Osteoarthritis
__ Other bone disease
__ Currently taking or history of bisphosphonates
__ None of the above

Blood
__ Anemia
__ Leukemia
__ Lymphoma
__ Taking blood thinner
__ None of the above

Neurologic
__ Epilepsy
__ Stroke
__ Parkinson's
__ Anxiety
__ Depression
__ Biploar
__ Anorexia or Bulimia
__ None of the above

Cancer
__ Cancer or tumor
__ Chemotherapy
__ Radiation therapy
__ HPV Positive (human papilloma)
__ Excessive sun exposure
__ None of the above

Immune Disorders
__ Chron's Disease
__ HIV/AIDS
__ Rheumatoid Arthritis
__ Sjogren's
__ Organ transplant
__ Lupus
__ Fibromyalgia
__ Chronic Fatigue
__ None of the above

Other
__ Frequent nausea or vomiting
__ Use tobacco
__ Current or history of substance abuse
__ Current or history of alcoholism

Please list medications and supplements you are currently taking:_____
_____
_____

Please list previous surgeries: _____
_____

Please list drug/food allergies:_____
_____

I understand the information I provided is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions accurately and to the best of my knowledge. Should further information be needed, you have my permission to ask the respetive health care provdier or agency who may release such information. I will notify the dentist of any change in my health or medications

_____ Date: _____
Signature of Patient, Parent, Guardian, or Representative

Consent Forms

PART V: DENTAL TREATMENT INFORMED CONSENT

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consent to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist, and all your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and intial the items below and sign at the bottom of the form.

___ 1. Treatment to be Provided: I understand that during the course of treatment, the following care may be provided: examinations, preventive services, restorations, crowns, bridges, and other services.
___ 2. Drugs & Medications: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.
___ 3. Changes in Treatment Plan: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
___ 4. I give permission to the dental office to bill my dental insurance provider for the treatment provided if applicable.
___ 5. I understand that if I cancel without at least a 24 hour notice or simply do not show for a scheduled appointment, I may be charged a $20 cancellation fee.
___ 6. I understand that if I am 15 minutes or more late for a scheduled appointment that I may be asked to reschedule and/or be charged a $20 cancellation fee.

Patient Signature: _____ Date: _____

Consent Forms

PART VI: PATIENT HIPAA CONSENT

I understand that as part of my healthcare, Midway Family Dental originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- a basis for planning in care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were provided
- and a tool for routine healthcare operations such as assessinig quality and reviewing the competence of healthcare professionals

I understand and have been proviided with a Notice of Informationi Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Midway Family Dental reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised noticie to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that Midway Family Dental is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Midway Family Dental has already acted in reliance thereon.

Please list any other people with whom we may share your personal information:

	Name	Relationship
1.)	_____	_____
2.)	_____	_____
3.)	_____	_____

Signature: _____

Date: _____

MIDWAY FAMILY
DENTAL

Release of Dental Records Consent

128 E. Main St. (P.O. Box 4122)
Midway, KY 40347
Phone: (859) 618-6311
Fax: (859) 403-2000
Email: contactus@midwaykyfamilydental.net

Patients Name:_____

Patient's DOB: _____

Requesting Dental Records From:_____

Dear Doctor,

I hereby authorize you to release any information or records regarding my dental treatment to Dr. Rachel Riley, DMD at the above address, via email or fax. Please send any current x-rays or other important information that would be beneficial to my dental health.

Thank you for your cooperation.

Patient Signature: _____

Date: _____