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:_____ MiddleInitial:_____ Prefered Name:_____
Birth Date: _____ Marital Status:_____ Gender:_____
Email: _____
Address:_____ City:_____ State:_____ Zip:_____
Home #:_____ Work #:_____ Cell #:_____

___ You have permission to email me ___ You have permission to text me

Patient's or Parent's Employer Information:
Employer:_____ Occupation:_____
Address:_____ City/State/Zip:_____

Emergency Information:
Person to Contact in case of an emergency:_____ Phone:_____

Who can we thank for referring you?_____

PART II: INSURANCE INFORMATION

Insured Information:
Name:_____ Relationship to Patient:_____
Birth Date:_____ SSI:_____ DL:_____
Employer:_____ Work #:_____
Address:_____ City/State/Zip:_____

Insurance Information:
Policy ID:_____ Group F:_____ Insurance Company:_____
Address:_____ City/State/Zip:_____ Union or Local #:_____

ASSIGNMENT AND RELEASE

I certify that I, and my 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 Rapresentative

PATIENT HEALTH HISTORY FORM

PATIENT NAME:_____

PART I : DENTAL CONCERNS

Please check all that you are concerned about or currently have. If none apply, please check "None of the above".

Focus and Overall Objective
__ Comprehensive evaluation
__ Limited Exam
__ Keep my teeth is important
__ None of the above

Jaw/Bite/Orthodontics
__ Jaw joint noise or clicking
__ Painful jaw, face or neck
__ Headaches
__ Ear pain
__ Teeth wearing down
__ None of the above

Teeth cleanings & Gum Disease
__ Bad breath
__ Worried about gum disease
__ Loose teeth
__ Bleeding gums
__ None of the above

Teeth and Fillings
__ Broken fillings
__ Broken teeth
__ Sensitive teeth
__ Toothache
__ Dark fillings
__ Tooth decay
__ None of the above

Dentures and Implants
__ Old dentures - don't like
__ Existing dentures not secure
__ Collapsed face
__ Can't chew with dentures
__ Interested in dental implants
__ None of the above

Sleep issues
__ Hate CPAP - Intolerant
__ Snoring or Sleep Apnea
__ Excessive daytime tiredness
__ None of the above

Cosmetics
__ Do not like smile
__ Have dark/stained teeth
__ Want whiter smile
__ Space/gaps between teeth
__ Dark lines around crowns
__ Crooked teeth
__ None of the above

Biologic
__ Mercury 'Amalgam' fillings
__ None of the above

PART II : MEDICATIONS, SUPPLEMENTS & SURGERIES

Please check all that APPLY If none apply, please check "None of the above".

1. Do you take care, have ever taken or have had any of the following:
__ Breathing medications
__ Antidepressants or sleeping pills
__ Aspirin or blood thinners
__ Dilatant or selzure medication
__ Immunosuppressants
__ Calcium channel blockers
__ Heart valve surgery
__ Joint or bone surgery
__ None of the above

2. Do you have any of these allergies or reactions:
__ Hay fever or sinus problems
__ Latex /rubber) sensivity
__ Aspirin
__ Penicillin or other antibiotics medicine
__ Codeine or other pain
__ Metals
__ Medication
__ Epinephrine
__ Sulfa drugs

3. Have you ever used a biosphosphonate medication? Fosamax, Actonel, Atelvia, Didronel, Boniva

YES NO

4. Have you ever taken any of the group of drugs collectively referred to as "fen-phen?". These include Lonimin, Adipex, Fastin, Pondimin, or Redux

YES NO

PLEASE LIST ANY PRESCRIPTION MEDICATIONS, SUPPLEMENTS, OR SURGERIES YOU HAVE HAD

PART III: MEDICAL SYSTEM

Please check all that you are concerned about or currently have. If none apply, please check "None of the above".

Cardiovascular

__ Heart murmur/damaged heart valve
__ Heart stent or angloplasty
__ Heart attack
__ Stroke
__ Angina, chest pain or discomfort
__ Congestive heart failure
__ Peripheral artery disease (PAD)
__ Swollen anides
__ Bleeding/clotting problems
__ High blood pressure
__ High cholesterol
__ Irregular or rapid heart beat
__ Heart pacemaker
__ None of the above

Endocrine Disorders

__ Thyroid problems
__ Pituitary or adrenal problems
__ Insulin resistant / Pre-diabetes
__ Diabetes - Type 1 (Insuline dependent)
__ Diabetes - Type 2 (Dillet and / or medication)
__ Diabetes - Type 2 (Insuline dependent)
__ Diabetes is controlled
__ None of the above

Cancer

__ Cancer or tumor, oral cancer
__ Chemotherapy or radiation therapy
__ HPV positive (Human Papilloma)
__ Excessive sun exposure
__ None of the above

ENT - Head & Neck

__ Headaches (migraine or tension)
__ Jaw joint popping/clicking
__ Limited mouth opening
__ Jaw, face, neck or back pain
__ Ear problems or pain
__ Mouth breather
__ Hay fever or sinus problems
__ Poor sleep
__ Daytime tiredness
__ Persistent sore throat/chronic cough
__ Chronic hoarseness
__ Unexplained numbness or pain
__ Difficulty chewing
__ Mouth sores 2 + weels in duration
__ Dentures with persistent sores
__ Difficulty swallowing
__ Difficulty moving jaw or tongue
__ Lump, swelling in mouth or neck
__ Numb mouth or tongue
__ None of the above

Sleep

__ Snoring
__ Daytime tiredness
__ Poor sleep
__ Gasp air / stop breathing during sleep
__ Large or thick neck
__ Obstructive sleep apnea
__ CPAP
__ Oral sleep appliance
__ Not currently using any therapy
__ None of the above

Other Disease & Conditions

__ Liver disease or Hepatitis
__ Tuberculosis
__ AIDS / HIV positive
__ Veneral disease
__ Chronic fatigue / Fibromyalgia
__ Arthritis or Rheumatism
__ Kidney disease
__ Osteoporosis (bone loss)
__ Add Reflux / Heartburn (GERD)
__ Frequent nausea / vomiting
__ Gastroinstestinal disease
__ Uclers, colitis or irritable bowel
__ Lung disease
__ Asthma
__ Emphysema or COPD
__ Epilepsy or Seizures
__ Memory problems
__ High stress or anxiety levels
__ Dental phobia / Fear
__ Depression
__ Immune system disorder
__ Sjogren's syndrome
__ Any bleeding disorder
__ Smoking
__ Smokeless Tobacco

Gender Health

Female:

__ Birth control pills
__ Pregnant or planning pregnancy
__ Nursing mother

Male:

__ Erectile dysfunction
__ None of the above

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 informaion to you. I will notify the doctor of any change in my health or medication.

PATIENT/GUARDIAN SIGNATURE

MIDWAY FAMILY
DENTAL

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES AND PRACTICES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting 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 initial the items below and sign at the bottom of the form.

____1. Treatment to be Provided: I understand that during my course of treatment that the following care may be provided: examinations, preventive services, restorations, crowns, bridges, and other services.

_____2. Drugs and 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 (severe allergic reaction).

_____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 routine 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 Name (print): _____

Patient Signature: _____

Date: _____

MIDWAY FAMILY DENTAL
128 E. MAIN ST
MIDWAY, KY 40347
859-618-6311
MIDWAYKYFAMILYDENTAL.COM

PATIENT HIPAA CONSENT FORM

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

- a basis for planning my 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 assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information 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 the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. 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 the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon.

Please list any other people with whom we may share your personal information, (i.e..Family, Friend, Partner)

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

Print Patient Name _____

Signature _____

Relationship to Patient _____

Date_____