St. Matthews Advanced Dentistry keeps a record of every visit you make to our office and we are committed to protecting the health information that is in that record. Typically, the record contains information about your current health plus our professional impression, diagnosis and treatment when needed. The record belongs to St. Matthews Advanced Dentistry, but the information in it is yours.

The St. Matthews Advanced Dentistry Notice of Privacy Practices is a detailed explanation of how we may use your health information and your right to inspect, copy and amend what is recorded. We are required by law and by our own code of ethics to keep this information about you private, to give you this Notice about our privacy practices and to follow the practices outlined in this Notice.

You have a right to a copy of this Notice and you should ask to receive one.

To receive a copy of our Notice, check one of the following:

_____ I am requesting a copy of St. Matthews Advanced Dentistry Notice of Privacy Practices.

_____ I do not wish to receive a copy of St. Matthews Advanced Dentistry Notice of Privacy Practices at this time. I reserve the right to request a copy at a later date.

St. Matthews Advanced Dentistry

148 Chenoweth Lane, Louisville, KY 40207
Tel 502.897.1677 Fax 502.895.5153

Patient's Name: _____ Preferred Name: _____ Today's Date: _____

Sex: M F Birth date: _____ Age: _____ SSN: _____

Please Check One: ☐ Single ☐ Married ☐ Separated Widow Occupation: _____

Home Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____

Home Phone # : _____ Work phone #: _____

Cell Phone #: _____ Fax #: _____

Your Employer: _____ How Long Employed: _____

Are you a full time student? Yes No

If patient is minor we need:
Mother's DOB: _____ *Father's DOB:* _____

Person responsible for account: _____ SSN: _____

E-mail address : _____

Home phone #: _____ Work phone #: _____

Cell phone #: _____ Fax #: _____

Employer: _____

How did you hear about our office? ☐ **Other patient (friend)** ☐ **Other patient (relative)**
☐ **Dental Office** ☐ **Yellow pages** ☐ **Newspaper** ☐ **School** ☐ **Work** ☐ **Other**
Name of person or office referring you to our practice: _____

EMERGENCY INFORMATION
Name, Address & phone of a relative not living with you: _____

_____

Reason for this visit _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's name: _____

DOB: _____ SSN: _____

Insured's employer: _____

Insurance Company: _____

Ins Co Address: _____

_____

Phone # _____

If you have a double insurance coverage, complete this for the second coverage

Insured's name: _____

DOB: _____ SSN: _____

Insured's employer: _____

Insurance Company: _____

Ins Co Address: _____

_____

Phone # _____

PATIENT Signature (Parent of Child) _____ **Date:** _____