Ty King D.D.S.
COMPREHENSIVE DENTAL CARE

Patient Name: _____ Preferred Name: _____ Date: _____

Address: _____ Birthdate: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Medicaid ID: _____

How did you hear about us? _____

Date of last dental cleaning / visit: _____

Responsible Party (If someone other than the patient)

Full Name: _____

Address: _____ Birthdate: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Place of Employment: _____

☐ Responsible Party is Primary Insurance Policy Holder ID: _____

☐ Responsible Party is Secondary Insurance Policy Holder ID: _____

Place of Employment: _____

MEDICAL HISTORY

List of Medications			**Conditions:**	**YES**	**NO**
			Acquired Immune Deficiency Syndrome (AIDS Virus)		
			Anemia		
			Asthma		
			Epilepsy		
			Diabetes		
			Heart Ailment		
			High Blood Pressure		
			Hyperthyroidism		
			Kidney Ailment		
Women Only	**YES**	**NO**	Liver Ailment or Hepatitis		
Are you pregnant?			Low Blood Pressure		
Are you taking birth control?			Multiple Sclerosis		
Are you breastfeeding?			Rheumatic Fever		
			Tuberculosis		
			Ulcers		

List of Medication Allergies	Conditions	YES	NO
	Antibiotic premedication required before dental procedure		
	Currently taking blood thinner		
	Severe Gag reflex		
	Joint replacements		
	Tobacco use		
	Other (Please List)		

DENTAL CONCERNS

	YES	NO
Bleeding Gums		
Hot/Cold Sensitivity		
Grinding/Clenching		
Cosmetic/Color of Teeth		
TMJ/Jaw Soreness		
Missing Teeth		
Other:		

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RECORDS CONSENT

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____

Patient/Guardian Signature

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges access to receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone # _____
☐ Email Confirmation Email_____
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation Email_____
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email_____
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ___ _____

Signature of Privacy Officer