



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:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone # _____ |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation Email _____ |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

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

- | | |
|--|---|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation Email _____ |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> 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:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email _____ | |

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

Financial Policies

Thank you for choosing Ty King D.D.S., Comprehensive Dental Care. We are happy to have you as our patient and look forward to offering you and your family quality dental care. We know that providing complete comprehensive dental services includes discussing all treatment and financial information. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. We believe that everyone benefits when specific financial arrangements are agreed upon.

Before any recommended treatment is performed, we will discuss the treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow time to make the necessary financial arrangements.

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa, Discover, MasterCard, American Express and Apple Pay. We do offer financing through our partnership with CareCredit.

Insurance

Your dental insurance policy is a contract between you and the providing company. Your insurance plan and payment is your responsibility. An insurance plan is not a guarantee of payment; it may not cover all the costs involved in treatment. Typically, dental insurance benefits are determined by your employer, or in cases of a self-policy, chosen by you.

As a courtesy, we will be glad to file the insurance claim for you once we have been provided your insurance card and all required details.

- You will be expected to pay for services rendered if our office is unable to verify your plan information before treatment.
- Any deductible or estimated co-payment amount will be due at the time of treatment.
- If payment for services already rendered has not been paid in full within 60 days by the insurance company, the remaining balance for your treatment is considered due and is owed by you.
- While our office will perform due diligence when verifying your insurance policy, it is ultimately your responsibility to know, understand and track insurance benefits, deductibles and maximums.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates

Scheduling

Appointments are reserved exclusively for you. If an appointment is cancelled with less than 24 hours' notice, or if you fail to keep your appointment, we reserve the right to charge and collect a fifty-nine-dollar (\$59) fee. There will be no fee for weather related cancellations, your safety is our priority. Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments. Excessive cancellations and no shows will result in dismissal from our practice.

This policy is in effect for all appointments at our office. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have read, understand and agree to this Financial Policy.

Printed Name

Signature

Date