NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital Status:	
Referral Source:		Employer:	
Referred By:		Occupation:	

Contact Information

Mobile Phone:	
Home Phone:	
Email:	

Address Information

Street Address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone Number:	
Relation:	

Work Information

Street Address:	
City:	
State:	
ZIP:	

Medical History Summary

Medical Conditions:	
Allergies:	
Medications:	

General Health Information

Are you currently under the care of a physician? ______ Yes ______ No

Physician’s Phone Number: ____________________

Date of last physician exam: ____________________

Are you presently being treated for any injury or illness? ______ Yes ______ No

Have you ever been hospitalized for an injury or illness? ______ Yes ______ No

Are you pregnant or planning to become pregnant? ______ Yes ______ No

Are you currently breastfeeding? ______ Yes ______ No

Do you require pre-med with antibiotics before dental treatment? ______ Yes ______ No

Do you use alcohol? ______ Yes ______ No

Do you use or have you ever used tobacco? ________ Yes ________ No
Have you ever had an allergic reaction? ________ Yes ________ No

Medical Conditions

Please check all conditions that you have history of or are being treated for:

Condition		
Do you have a history or are currently being treated for any Digestive conditions?	________ Yes	________ No
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	________ Yes	________ No
Do you have a history or are currently being treated for any Neurological conditions?	________ Yes	________ No
Do you have a history or are currently being treated for any Lung or Breathing conditions?	________ Yes	________ No
Do you have a history or are currently being treated for any Autoimmune conditions?	________ Yes	________ No
Head or neck injuries?	________ Yes	________ No
Artificial Joint?	________ Yes	________ No
High cholesterol?	________ Yes	________ No
History of cancer?	________ Yes	________ No
Tumor or abnormal growth?	________ Yes	________ No
Radiation therapy?	________ Yes	________ No
Chemotherapy?	________ Yes	________ No
HIV / AIDS?	________ Yes	________ No
Osteoporosis /osteopenia?	________ Yes	________ No
Type I or Type II diabetes?	________ Yes	________ No
Anemia?	________ Yes	________ No
Kidney disease?	________ Yes	________ No
Liver disease?	________ Yes	________ No
Thyroid disease?	________ Yes	________ No
Tuberculosis / measles / chicken pox?	________ Yes	________ No

Any other medical condition we should know of? ____

Medications

Medication		
Are you taking any pain medications?	________ Yes	________ No
Are you taking any Antidepressants or Anxiety medications?	________ Yes	________ No
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	________ Yes	________ No
Are you taking any Allergy or Asthma medications?	________ Yes	________ No
Are you taking any Antibiotics?	________ Yes	________ No
Are you currently taking any other medications or dietary supplements?	________ Yes	________ No

Patient's Signature: ______________________________ **Date:** ______________

Doctor's Signature: ______________________________ **Date:** ______________

FINANCIAL POLICY

FINANCIAL POLICY:

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS** and **DEDUCTIBLES** are due at the time of service, unless other arrangements are made.

UNPAID BALANCES over 90 days old will be subject to monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorney fees, and court costs associated with the recovery of monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged $50. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Policy.

Patient Name (Print): ____ Date: _____________

Patient Signature: ____

OFFICE POLICIES FORM

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 604 E Blvd St, Suite A, Kokomo, IN 46902.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. IN addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. Special instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the client's medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the Psychotherapy Notes definition is the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider

to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d)) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient Name (Print): ____ Date: ____________

Patient Signature: ____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION:

Policy Holder's Information:

Name: ____ DOB: _____________

SSN: _____________________________

Home Address: ______________________________City:_____________ State:_____ ZIP:_________

Phone Number: _______________________________

Employer: ____

Dental Insurance Company:

ID Number: __________________________

Group Number: ___________________________

Phone number on the back of the insurance company: ___________________________________

Address on the back of your insurance company: _______________________________________

SECONDARY INSURANCE INFORMATION:

Policy Holder's Information:

Name: ____ DOB: _____________

SSN: _____________________________

Home Address: ______________________________City:_____________ State:_____ ZIP:_________

Phone Number: _______________________________

Employer: ____

Dental Insurance Company:

ID Number: __________________________

Group Number: ___________________________

Phone number on the back of the insurance company: ___________________________________

Address on the back of your insurance company: _______________________________________

HIPAA - RELEASE OF INFORMATION AUTHORIZATION FORM

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), must first be authorized. Authorization includes the signature of the individual authorizing the release of their information. Information will not be available to anyone other than the covered patient (i.e., a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year-old dependent, that information will not be given to Information Regarding Person Authorizing Releasing His/Her Information:

Name of person authorizing release	
Date of Birth of person authorizing release	
Personal Information to be released	

The following is an authorization allowing Kokomo Family Dentistry to release information to whomever you designate. Kokomo Family Dentistry is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization to whom the office may release information	
Relation of person/organization to whom the office may release information	
Phone number of person/organization to whom the office may release information	

I want to add a second person/organization:

Name of person/organization to whom the office may release information	
Relation of person/organization to whom the office may release information	
Phone number of person/organization to whom the office may release information	

I want to add a third person/organization:

Name of person/organization to whom the office may release information	
Relation of person/organization to whom the office may release information	
Phone number of person/organization to whom the office may release information	

AUTHORIZATION CONSENT: I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practices Notice of Privacy Practices.

Patient Signature: ____ Date: ____________________