KOKOMO
Family Dentistry

PATIENT INFORMATION 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:	

Kokomo Family Dentistry has permission to contact me with appointment reminders or other communication via the following: □ Text □ Email Preferred Phone #: □ Home □ Cell

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:

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

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

By signing below, I attest that the above information is accurate and complete to the best of my knowledge. I have also received/been offered a copy of the office's Notice of Privacy Practices to review.

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: _____

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ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all dental benefits, including major dental benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other dental plan to issue payment check(s) directly to Kokomo Family Dentistry for dental services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Kokomo Family Dentistry to (1) release any information necessary to insurance carriers regarding my treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested dental services from Kokomo Family Dentistry on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original

_____

Patient Name (Print)

_____ _____

Patient/Responsible Party Signature Date

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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: _____

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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 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 parent calls about the status for a claim on a 19-year-old dependent, that information cannot released unless the patient has listed the parent below as a designated party to which information may be given.

Patient Information:

Patient Name	
Date of Birth	

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 practice's Notice of Privacy Practices.

Patient Signature: _____ Date: _____