KENT DENTAL

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Name of Healthcare Provider: Kent Dental; 20511 N. Hayden Rd. Suite 150, Scottsdale, AZ 85255 / 480-994-5555 / FrontDesk@KentDental.com

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information.

All records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse.

I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

_____

Date

KENT DENTAL

PATIENT INFORMATION

Date: ☐ New Patient ☐ Update

Patient:

Last First MI Preferred Title

☐ Male ☐ Female ☐ Child* ☐ Student** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

*If Child, provide parent/guardian name(s) below:

Parent/Guardian Name(s)

**If Student, please complete: ☐ Full-time ☐ Part-Time

School/Location

Patient Date of Birth: Patient SSN:

Address:

Address Line 1

Address Line 2

City ST ZIP Code

Home:

Cell:

Other:

E-Mail:

Referral? ☐ Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

Name Relationship Tel:

MEDICAL INFORMATION

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

INSURANCE INFORMATION

Subscriber:

Last First MI Preferred Title

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Primary Insurance Carrier:

Group/Policy No.: ID No.:

Address: Tel:

Toll-free:

Fax:

City ST ZIP Code

Secondary Insurance Carrier:

Group/Policy No.: ID No.:

Address: Tel:

Toll-free:

Fax:

City ST ZIP Code

KENT DENTAL

MEDICAL HISTORY

YOUR CURRENT DENTAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Any hospitalization in the past 5 years? .....
☐Y☐N Any serious illnesses/surgeries? .....
☐Y☐N Use tobacco in any form? If Yes, Type: .....
☐Y☐N Use of recreational drugs?
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Do you or have you ever experienced discomfort in your jaw joint (TMJ / TMD)?
☐Y☐N Do you have sleep apnea?
☐Y☐N Have you had a sleep apnea study in the last 5 years?
☐Y☐N Do you snore?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: .....

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

.....

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

.....

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ABNORMAL BLEEDING
☐ALCOHOL / DRUG ABUSE
☐AIDS/HIV+
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐BLOOD TRANSFUSION
☐CANCER/CHEMOTHERAPY
☐COLITIS
☐CONGENITAL HEART DEFECT
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIFFICULTY BREATHING
☐DIZZINESS/FAINTING
☐EMPHYSEMA
☐EPILEPSY/SEIZURES
☐FREQUENT HEADACHES
☐GLAUCOMA
☐HAY FEVER
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEART SURGERY
☐HEPATITIS A / B / C
☐HIGH BLOOD PRESSURE
☐HOSPITALIZED
☐KIDNEY PROBLEMS
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐PACEMAKER
☐OTHER – PLEASE LIST: .....
☐PSYCHIATRIC PROBLEMS
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐SLEEP DISORDER
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐NONE

☐ASPIRIN
☐CODEINE
☐DENTAL ANESTHETIC
☐ERYTHROMYCIN
☐JEWELRY / METALS
☐LATEX
☐PENICILLIN
☐TETRACYCLINE
☐SULFA
☐OTHER – PLEASE LIST: .....

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER (PLEASE LIST BELOW)
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

Signature:_____ **Date:** _____

KENT DENTAL

Welcome. To better server you, please take just a couple of minutes to answer the following questions.

Please check any of the following problems that apply to you:

- ○ Sensitivity (hot, cold, or sweet)
  If so, which teeth?

- ○ Headaches, earaches, neck pain
- ○ Teeth or fillings breaking
- ○ Grinding or clenching teeth
- ○ Bleeding, swollen, or irritated gums
- ○ Loose, tipped or shifting teeth
- ○ Bad breath

Do you have any of the following?

- ○ Dentures
- ○ Partials dentures
- ○ Periodontal (gum) treatments

Please share the following approximate dates:

Your last cleaning _____
Your last oral cancer screening _____
Your last complete x-rays _____

Who was your previous dentist?
Name: _____
City: _____ State: _____
Phone: _____

Has your doctor told you that you require antibiotics before dental treatment?
◯ YES ◯ NO

Your current dental health is
◯ Good ◯ Fair ◯ Bad

Do you like your smile?
◯ YES ◯ NO

Do your gums bleed?
◯ YES ◯ NO

How many times do you brush your teeth?
_____

How many times a week do you clean between your teeth? _____
◯ Floss ◯ Waterpik ◯ Other

Does any aspect of having dentistry done make you nervous or scared?
◯ YES ◯ NO

If you could change your smile, would you:
(please check all that apply)

- ○ Make your teeth whiter
- ○ Make your teeth straighter
- ○ Close spaces between your teeth
- ○ Replace black metal fillings with tooth colored restorations
- ○ Repair chipped teeth
- ○ Replace missing teeth
- ○ Replace old crowns that don't match
- ○ Have a smile makeover

On a scale of 1 to 5, with 5 being the highest reading: (please circle the number that best applies)

How important is your dental health to you?
1 2 3 4 5

How would you rate your current dental health?
1 2 3 4 5

Where do you want your dental health to be?
1 2 3 4 5

Please answer the following questions.

What are the most important things to you about your smile?

If you could whiten your teeth, at a cost that any would could afford would you like to?

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit today?

KENT DENTAL

Financial Guidelines

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express and Discover. Outside financing is available upon request and approval.

Please note: returned checks will be subject to additional fees. In case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred.

Do You Have Insurance?

- As a courtesy to you, we will help you process all your dental insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as we have estimated. Your insurance company and your plan benefit ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Our office is not a party to that contract.

- 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.

- We ask that you sign this form and/or any necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company by cash, check, MasterCard, Visa, American Express or Discover at the time we provide the service to you.

- Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be made responsible for paying the full amount at that time.

- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health needs and welcome any questions you may have concerning our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

PATIENT Signature (Parent of Child) Date:

_____ _____

KENT DENTAL

PATIENT NAME: _____ Date of Birth: _____

MEDICAL HISTORY

YOUR CURRENT DENTAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR ADDRESS/PHONE UPDATE? ☐Y☐N INSURANCE UPDATE? ☐Y☐N

☐Y☐N Any hospitalization in the past 5 years?
☐Y☐N Any serious illnesses/surgeries?
☐Y☐N Use tobacco in any form? If Yes, Type:
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☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
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☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
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☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

ADRESS UPDATE: _____ **PHONE UPDATE:** _____

_____ **INSURANCE UPDATE:** _____

_____ _____

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

Signature:_____ **Date:** _____

KENT DENTAL

PHOTO RELEASE FORM

I hereby authorize Kent Dental to publish the photographs and/or video taken of me, and my name, for use in Kent Dental's printed publications, newsletter releases, online, and in other communications related to the mission of Kent Dental. I acknowledge that since my participation in publications and other forms of media produced by Kent Dental, is voluntary and I will receive no financial compensation.

I further agree that my participation in any publications and other forms of media produced by Kent Dental confers upon me nor rights of ownership whatsoever. I release Kent Dental, its contractors and its employees from liability for any claims by me or any third party in connection with my participation.

_____

(Signature of Adult, or Guardian of Children under age 18)

Patient Name _____

Date _____

Thank you!

KENT DENTAL

Cancellation and No-Show Policy

First Name: _____ Last Name: _____

We understand that situations arise that you are unable to control and are forced to cancel your appointment. We ask that you cancel your appointment as soon as you are aware your situation has changed and no less than 48 hours in advance. With cancellation less than 48 hours we are unable to fill the appointment with someone who is on our waiting list, resulting in lost time and production.

Office appointments which are canceled with less than 48 hours' notice are subjected to a $50.00 cancellation fee.

The Cancellation and No-Show fees are the sole responsibility of the patient and will be due prior to your next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived or reduced but only with management approval.

Our practice firmly believes in a good doctor/patient relationship is based on understanding and good communication. Questions about cancellation and no-show fees should be directed to the billing department.

Please sign below acknowledging your understanding and agreement to our cancellation and no-show policy.

_____ _____

Patient Signature Date