

Deidra Bird Kokel, D.D.S., PC
**ACKNOWLEDGEMENT OF RECEIPT OF
“NOTICE OF PRIVACY PRACTICES”**

****You may refuse to sign this acknowledgement****

I, _____, have received a copy of this office’s “Notice of Privacy Practices.”

(Please print name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our “Notice of Privacy Practices,” but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

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This form is educational only; it does not contain legal advice. It covers only federal, not state, law (August 14, 2002).

Patient Information

Patient Name: _____ Date: _____
Last First MI

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ ext.: _____

Cell: _____ e-mail: _____

Address: _____
Street Apartment #

City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="radio"/> AIDS | <input type="radio"/> Drug Allergies | <input type="radio"/> Heart Disease | <input type="radio"/> Pregnancy – Due Date: _____ |
| <input type="radio"/> Allergies | ___ Codeine | <input type="radio"/> Heart Murmur | <input type="radio"/> Radiation Treatment |
| ___ environmental | ___ Epinephrine | <input type="radio"/> Hepatitis | <input type="radio"/> Respiratory Problems |
| ___ food | ___ Motrin | <input type="radio"/> High Blood Pressure | <input type="radio"/> Rheumatic Fever |
| ___ nuts | ___ Penicillin | <input type="radio"/> Jaundice | <input type="radio"/> Rheumatism |
| ___ seasonal | ___ Sulfa drugs | <input type="radio"/> Kidney Disease | <input type="radio"/> Sinus Problems |
| <input type="radio"/> Anemia | ___ Tetracycline | <input type="radio"/> Latex Allergy | <input type="radio"/> Stomach Problems |
| <input type="radio"/> Arthritis | <input type="radio"/> Epilepsy | <input type="radio"/> Liver Disease | <input type="radio"/> Stroke |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Lupus | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Asthma | <input type="radio"/> Fainting | <input type="radio"/> Lyme's Disease | <input type="radio"/> Tumors |
| <input type="radio"/> Blood Disease | <input type="radio"/> Glaucoma | <input type="radio"/> Mental Disorders | <input type="radio"/> Ulcers |
| <input type="radio"/> Cancer | <input type="radio"/> Growths | <input type="radio"/> Nervous Disorders | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Diabetes | <input type="radio"/> Hay Fever | <input type="radio"/> Pace Maker | <input type="radio"/> Other: _____ |
| <input type="radio"/> Dizziness | <input type="radio"/> Head Injuries | <input type="radio"/> PRE-MED | |

Please list current medications: _____

Have you ever had any complications following dental treatment? yes no

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? yes no

If yes, please explain: _____

Are you now under the care of a physician? yes no

If yes, please explain: _____

Name of physician: _____ Phone: _____

Do you have any health problems that need further clarification? yes no

If yes, please explain: _____

Have you ever had periodontal treatment? yes no

Are you dissatisfied with the appearance of your teeth? yes no

If yes, what would you most like to change? _____

Have you ever had an unfavorable reaction to local anesthetic? yes no

If yes, please explain: _____

Why did you leave your last dental office? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? another patient (friend) another patient (relative)
 dental office yellow pages newspaper school work other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

male female married single child other

Social Security #: _____ Birth Date: _____

Phone (home): _____ (work): _____ ext: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? yes no

Last

First

MI

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: self spouse child other _____

Insurance Plan Name: _____

Address: _____

Street

City

State

Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient, and that he or she is personally responsible for payment of all dental services. This office will help to prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me (or at my request) by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment, and I agree to their content.

Date: _____ Relationship to patient: _____

Signature of Patient, parent or guardian

Date: _____ Relationship to patient: _____

Signature of guarantor of payment/ responsible party