KILDAIRE FAMILY & COSMETIC DENTISTRY
NEW PATIENT INTAKE FORM

TEAM MEMBER: _____ DATE: _____

PATIENT NAME: _____

MOBILE PHONE #: _____ OTHER PHONE #: _____

REASON FOR THE CALL: _____

AREA OF CONCERN: _____

"HOW DID YOU HEAR ABOUT OUR PRACTICE?": _____

DOB:_____ Parent/Guardian (if applicable): _____

PATIENT'S EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____

"Do you have dental insurance coverage?" YES ☐ NO ☐

PRIMARY DENTAL INSURANCE INFORMATION

SUSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____

SUSCRIBER DOB: _____ SUSCRIBER SS#: _____

EMPLOYER: _____

INSURANCE COMPANY: _____ INS PHONE #: _____

GROUP #: _____ SUSCRIBER ID #: _____

OUR PROVIDERS ARE IN-NETWORK WITH THE FOLLOWING CARRIERS:
BCBS, Cigna PPO, Delta Dental Premier

OTHER QUESTIONS

Have you been to another dental office within last 12 months? YES ☐ NO ☐

Previous Dentist: _____ Provider Phone #: _____

"Have you been told you need Pre-Med before dental appointments?" YES ☐ NO ☐

"Are you Pregnant?" YES ☐ NO ☐

"Do you currently see a healthcare specialist?" YES ☐ _____ NO ☐
(i.e. cardiologist, oncologist, neurologist)

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MEDICAL HISTORY

Patient: _____

NO YES Allergy - Aspirin

NO YES Allergy - Codeine

NO YES Allergy – Latex

NO YES Allergy – Local Anesthetic

NO YES Allergy – Penicillin

NO YES Allergy – Sulfa

List any other allergies:

_____

_____

NO YES Arthritis / Rheumatism / Gout

NO YES Artificial Joint / Bones

NO YES Asthma

NO YES Cancer

NO YES Chemotherapy

NO YES Diabetes

NO YES Emphysema

NO YES Glaucoma

NO YES Radiation Treatment (Xray/Cobalt)

NO YES Shortness of Breath (Breathing Problems)

NO YES Sinus Trouble

NO YES Stroke

NO YES Thyroid Problems

NO YES Tuberculosis

NO YES Tumor / growth on head / neck

NO YES Ulcer

NO YES Do you Smoke?

NO YES Do you drink Alcohol?

NO YES High Sugar Intake?

NO YES Abnormal (High/Low Blood Pressure)

NO YES AIDS/HIV

NO YES Anemia /Bleeding Problems

NO YES Artificial Heart Valve

NO YES Blood Disease

NO YES Congenital Heart Lesions

NO YES Heart Problems

NO YES Pacemaker

NO YES Epilepsy

NO YES Fainting / Dizziness

NO YES Headaches (Frequent)

NO YES Hepatitis

NO YES Herpes

NO YES Kidney Disease

NO YES Liver Disease

NO YES Nervous Problems

NO YES Psychiatric Care

List any other medical issues you have: _____

_____

List any serious illness / surgeries / hospitalizations:

_____

_____

List any medications you are taking:

_____

_____

_____

NO YES Pregnant

NO YES Nursing

Signature:_____

Date:_____

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FINANCIAL POLICY

As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. The practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient or patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the management's discretion, for payments in full with cash or check. (Inquire for more details.)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan but any balance that remains on your account, whether your insurance company covered the procedure in question or not, is ultimately your responsibility to pay.

A service charge of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, I agree to pay the reasonable value of said services to said doctor, or his 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 allotted 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 Kildaire Family and Cosmetic Dentistry and/or Kildaire Family and Cosmetic Dentistry Practice's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.

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

Signature of patient, parent or guardian	**Date**	**Relationship to patient**
Signature of guarantor of payment/responsible party	**Date**	**Relationship to patient**

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APPOINTMENT AGREEMENT

At Kildaire Family and Cosmetic Dentistry, we understand that your time is very valuable. We are constantly striving to ensure that your experience here with us is pleasant and exceeds your expectations. Trying to accommodate every patient's individual needs coupled with everyone's work schedules can be challenging. We make every effort to stay on time and be efficient so that our patients will not have to wait unnecessarily or experience delays. Your appointment with us is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. This time is set aside specifically for you.

As a courtesy to our patients, we offer appointment reminder notifications at various intervals prior to each appointment. Patients will receive a text, e-mail, and/or phone call notification as follows: the day the appointment is scheduled; then two (2) weeks prior to the appointment; then three (2) days prior to the appointment; lastly a few hours before the scheduled appointment. Please respond to this message "confirming" the appointment and notifying us that you will be present and on time. We make every effort to confirm our appointments. If you have not confirmed your appointment with us more than twenty-four (24) hours prior to the scheduled reservation, your appointment may be filled by another patient. Therefore, it is essential that we obtain all pertinent contact information and that we communicate with one another prior to the appointment.

If you have confirmed or not confirmed your appointment and find that you cannot keep your appointment, we require a **minimum notice of twenty-four (24) hours** so we are able to assist other patients with their dental needs. If our office is not notified prior to the twenty-four (24) hour window preceding the appointment, you will be charged a **Fifty Dollar ($50.00) Broken Appointment Fee.** Appointments are scheduled as individuals. Therefore, if more than one (1) family member has a broken appointment (whether on the same day or not), these occurrences will be treated as multiple broken appointments and will incur separate "Broken Appointment Fees."

After the first broken appointment, patients with high production appointments (defined as appointments with a projected treatment value of one thousand dollars ($1,000.00) or more and/or are reserved for one (1) hour or more in total time reserved) will be subject to paying twenty-five percent (25%) of the estimated patient portion up front in order to reserve the appointment. This pre-payment will be held by the practice on the patient's account and applied to the balance owed once treatment is completed.

Also, if any patient accrues more than two (2) broken appointments in a twelve (12) month period, Kildaire Family and Cosmetic Dentistry reserves the right to release that patient from care and be dismissed from the practice.

Thank you for understanding and respecting the importance of this policy.

By signing below, I agree to fulfill my obligation as a patient at Kildaire Family & Cosmetic Dentistry and I agree to the "Broken Appointment Fee" and pre-payment penalties, should I not give proper notification.

_____ _____

Signature of Patient or Responsible Party **Date**

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Vital Information About Your Dental Insurance

As a Courtesy to you, we will be happy to file **YOUR** insurance. Your dental insurance is a contract between **YOU** and **YOUR INSURANCE CARRIER**. Dental benefit plans can vary from company to company with different procedures covered or not covered and it will be **YOUR** responsibility to know this information including but not limited to whether we are a network provider for **YOUR** insurance carrier.

Your Insurance plan will pay only what it allows for each service, regardless of what the actual fee might be.

Your Employee Benefits Director can usually help you become familiar with your plan and it's restrictions, and our office will assist you in maximizing your benefits.

OUR RESPONSIBILITIES:

1. Complete your insurance claim forms and submit them to your carrier for you within 24 hours of treatment.
2. Follow-up with your insurance regarding claim questions.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time within a 60 day period.

YOUR RESPONSIBILITIES:

1. To pay fees **ESTIMATED** not to be covered by **YOUR** insurance at the time of treatment.
2. To pay any account balance not paid by **YOUR** insurance.
3. To provide our office with current insurance information and notify us with any changes in coverage to allow correct filing of claims.
4. To be aware of **YOUR** plan benefit details.

Signature of Patient or Insured

I hereby authorize payment directly to the dental office of the Insurance benefits otherwise payable to me. I understand that I am ULTIMATELY responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers.

Patient or Insured **Date**

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential information of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing this form, I agree to allow the use and disclosure of my medial record information for the purposes described above. A copy of this authorization (consent) form will be given to me.

Signature_____ Date_____

Please contact us for more information:
Kildaire Family and Cosmetic Dentistry
3420 Ten- Ten Road #310
Cary, NC 27518
(919)342-8509
www.kildairefamilydental.com

For more information about HIPAA or to file a complaint, contact
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington, DC 20201
(202) 619-0257 or Toll Free 1-877-696-6775

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth _____

Mailing Address _____
Street address City State Zip

Kildaire Family and Cosmetic Dentistry is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Check entity/person that you approve to Receive information.	**Check description of information to be released to entity/person at left.**
☐ Voice Mail (Home or Mobile)	☐ Appointment Reminders
☐ Email _____ (Provide Email Address)	☐ Appointment Reminders, X-Rays, Financial
☐ Spouse _____ (Provide Name and Phone Number)	☐ Appointment Reminders ☐ Financial ☐ Treatment Plans
☐ Parent _____ (Provide Name and Phone Number)	☐ Appointment Reminders ☐ Financial ☐ Treatment Plans
☐ Other _____ (Grand-parent, Step-parent, Nanny) (Provide Name and Phone Number)	☐ Appointment Reminders ☐ Financial ☐ Treatment Plans

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative Date