IUKA FAMILY DENTAL

Please initial here to give us permission to take your picture; it may be used in a positive way on our social media pages_____

Please initial here to decline_____

Patient Information (please print)

NAME_____PERFERRED NAME_____

BIRTH DATE_____ SS#_____ MALE FEMALE

MAILING ADDRESS_____CITY_____STATE_____ZIP_____

E-MAIL_____

HOME PHONE_____CELL PHONE_____WORK_____

MINOR SINGLE MARRIED OTHER

Emergency Contact: (please list relationship to patient and phone number)_____

Family Doctor_____Pharmacy_____

EMPLOYER_____

PATIENT'S SPOUSE or LEGAL GUARDIAN (please COMPLETE in FULL)

NAME_____ MALE FEMALE ------ SINGLE MARRIED OTHER

BIRTHDATE_____ SS#_____

HOME PHONE_____CELLPHONE_____WORK_____

ADDRESS_____

EMPLOYER_____

DENTAL INSURANCE INFO (lack of insurance info can result in cash payment or rescheduled appointment)

INSURANCE COMPANY_____GROUP#_____ID#_____

NAME OF INSURED_____EMPLOYER_____

RELATION TO PATIENT_____

BIRTH DATE OF INSURED_____SS#_____

DO YOU HAVE A SECONDARY DENTAL INSURANCE: YES NO

SECONDARY INSURANCE COMPANY_____EMPLOYEE_____

BIRTH DAY OF EMPLOYEE_____SS#_____

PLEASE LIST ANY HEALTH PROBLEMS AND MEDICATIONS YOU ARE CURRENTLY TAKING:

PLEASE CHECK ANY ALLERGIES YOU HAVE:

LATEX___ PENICILLIN___ IBUPROFEN___

KEFLEX___ ASPRIN___ SULFA DRUGS___

LOCAL ANESTHETICS___ CODEINE____

PLEASE LIST ANY OTHER ALLERGIES NOT LISTED ABOVE:

PLEASE CHECK EACH BOX THAT APPLIES TO YOU AND YOU AND YOUR MEDICAL HISTORY

___USING TOBACCO PRODUCTS

___ARTIFICAL JOINT REPLACEMENT (IF YES, LIST YEAR OF SURGERY) ____

___CANCER OR TAKING TREATMENTS

___HIGH BLOOD PRESSURE

___HEART MURMUR

___CONGENITAL HEART DEFECTS

___ANY OTHER HEART CONDTION NOT LISTED

___DIABETES (LIST TYPE) ____

___ULCERS

___ANEMIA

___HEPATITIS (LIST TYPE) ___

___ASTHMA

___KIDNEY DISEASE OR DIALYSIS

___OSTEOPOROSIS

___GLAUCOMA

___THYROID PROBLEMS

___ AIDS/HIV

___ SINUS PROBLEMS

___TUBERCULOSIS OR LUNG DISEASE

___EPILEPSY OR SEIZURES

___CURRENTLY PREGNANT OR NURSING

SIGNATURE_____DATE_____

IUKA FAMILY DENTAL

OFFICE PAYMENT POLICY AND AGREEMENT

We appreciate your selection of our office to serve your dental health needs. To avoid misunderstandings concerning payment of accounts, please note that **PAYMENT IN FULL** is required for **ALL** dental treatment. We will be happy to file insurance claims for you at no extra charge, if the insurance company will also issue a check payable to the dentist. In addition, you must provide our office staff proper information (Dental Insurance card, social security #, and date of birth of the person you are filing dental insurance under). The *estimated* difference that the insurance does not pay is your responsibility and must be paid the day of each visit.

Your insurance is a contract between you as a subscriber, and the insurance company as insurer, involving our office, Iuka Family Dental, only indirectly. Therefore, any controversy which might arise over your insurance company's handling of your claim is for you to resolve. Any discrepancy between the insurance company's allowance and your total indebtedness remains your responsibility. **Any insurance claim that has not been paid within 45 days of treatment will be billed back to you**. We are a PPO provider for a select few insurance companies, please be familiar with your policy. These stipulations also apply to ALL CHIPS recipients.

A quote of insurance does not guarantee payment from your insurance company. You will be mailed a statement after each visit with final balance. Please open all mail from us you receive. Any account that has not been paid within 45 days after service will be referred to a collection agency or a collection attorney. A returned check fee of $40.00 will be charged for all returned checks. Also, any appointments missed without a 24 hour advanced notice phone call may be subject to a "missed appointment fee" per patient per appointment. This fee will have to be paid in full prior to any further appointments being made.

( ) I have dental insurance and will pay my portion today.

( ) I will pay in full

( ) I will charge to Master Card____Visa____Care Credit_____Citi Health_____

I hereby assign, transfer, and set over to Iuka Family Dental all rights, title and interest to my dental reimbursement benefits under my insurance policy. I authorize the release of any dental information needed to determine these benefits.

This agreement affects all services and charges present and future; and this authorization shall remain valid until written notice is given by me revoking said authorization.

I authorize the verification of my employment by this office or in the event my account becomes delinquent, by any collection agency or law firm to which my account is referred.

I understand I am financially responsible for all charges for my dependents or myself whether or not they are covered by insurance. In the unlikely event this account is submitted for collections, I the undersigned agree to pay any and all collection costs and reasonable attorney fees.

I, the undersigned, agree to all of the terms stated and promise to pay accordingly.

Guarantor Signature: _____ Date: _____

Co-Guarantor Signature: _____ Date: _____

PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

FOR

IUKA FAMILY DENTAL

EDWARD S. KNIGHT, DDS

MARK R. MAZURKIEWICZ, DMD

C. WILLIAM BAILEY, DMD

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan, and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third party payers.**
- **Conduct normal health care operations such as quality assessments and physician referrals.**

Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read the privacy notice and sign this consent.

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

Patient Name (please print) _____

Signature_____

(If child) Relationship to patient_____

Date_____

Please list anyone besides the patient or guardian that has the right to make appointments, discuss treatment, or discuss account balances. All other stipulations above apply.