Nykiel Dentistry

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Welcome! We look forward to meeting you and working together with you to provide the best care for your dental needs.

Please take a moment to read and fill out the attached forms that will assist us in providing the best care for you. If your physician has advised you to premedicate prior to dental treatment, please inform us before your appointment.

Copies of your most current dental x-rays from your current or previous dentist would be helpful with providing the best service for you. You can request the records yourself or we can request them for you. However, many practices require you to sign a Release of Records form.

Included in this packet is a HIPAA/Notice of Privacy Practices consent form. A full copy of our HIPAA Privacy Notice is available at our office or on our website, www.nykieldentistry.com. Please complete and sign all of the forms in this packet. You can bring them with you to your appointment, email them to us at nykieldentistry@securedds.com or FAX them to us at (734) 676-6646.

Please refer to the enclosed **Office Policy** so that you fully understand our financial expectations and policies.

REGISTRATION

Patient's Last name_____ First Name _____ Middle Initial_____

Address_____ Birthdate _____/_____/_____ Age _____ Sex M/F

Social Security # _____/_____/_____ Email _____ Contact Preference (circle): Email/Text/Phone

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Address_____Occupation_____

Spouse's Name _____ Spouse's Occupation _____

Who is Responsible for Account (if different from patient) _____ Birthdate_____/_____/_____

Relationship to Patient _____ Address _____

Phone _____ Email _____ Contact Preference (circle): Email/Text/Phone

***Who may we thank for referring you to our practice**: _____

DENTAL INSURANCE

Name of Insured _____ DOB ____/____/____ Insurance Carrier _____

Employer_____ Social Security or ID # _____ Group # _____

Customer Service Phone # _____

ADDITIONAL INSURANCE COVERAGE

Name of Insured _____ DOB ____/____/____ Insurance Carrier _____

Employer _____ Social Security or ID # _____ Group # _____

Customer Service Phone # _____

MEDICAL

Name of Primary Care Physician _____ Phone # _____

Name of Specialist _____ Phone # _____

Date of Last Physical Exam _____

Current Medications, Dose and Frequency or provide list to copy _____

_____

Do you use Tobacco ☐ YES ☐ NEVER ☐ Previously Quit Date _____

Do you use Recreational Drugs? ☐ YES ☐ NO If so, type/ frequency _____

Do you have a Pacemaker? ☐ YES ☐ NO

Do you take Bisphosphates? ☐ YES ☐ NO

Are you Allergic to Latex? ☐ YES ☐ NO

Are you required to Premedicate for your dental appointment? ☐ YES ☐ NO Name of medication _____

Are you Allergic or Sensitive to any medications? ☐ YES ☐NO

☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Codeine ☐ Narcotics ☐ Barbiturates ☐ Other _____

Do you have or have you had any of the following? Check all that apply:

☐ Aids
☐ Alcohol Abuse
☐ Anemia
☐ Artificial Joints
☐ Arthritis
☐ Allergies _____
☐ Asthma
☐ Cancer: Type _____ Date _____
☐ Chemotherapy: Date _____
☐ Congestive Heart Failure
☐ Depression
☐ Diabetes: Type _____
☐ Drug/Substance Abuse
☐ Epilepsy
☐ Excessive Bleeding
☐ Esophageal Reflux
☐ Fainting Tendencies
☐ Fever Blisters
☐ Headaches
☐ Heart Attack
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Herpes
☐ High Blood Pressure
☐ HIV
☐ Kidney/Bladder disease
☐ Liver Disease
☐ Lung Disease
☐ Lupus
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Radiation: Date_____
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stroke
☐ Tumors/Growths
☐ Tuberculosis
☐ Venereal Disease

List any other conditions not mentioned above _____

_____

Have you had Heart Surgery? ☐ YES ☐ NO Explain Procedure _____

_____

Women Only: Are you ☐ Pregnant ☐ Nursing If Pregnant, how many months? _____

Sign _____ Date _____

OFFICE POLICIES

It is your responsibility to keep all appointments. If you cannot keep your scheduled appointment time, we kindly ask that you give the office a 24-hour advance notice so that we may offer your reserved time to another patient in need of care. Missed appointments or canceled appointments without a 24-hour advance notice are subject to a $25 charge.

Payments are due at the time of visit. This includes the patient's estimated portion and deductible amounts. For your convenience, we accept cash, check, VISA, Discover, American Express, MasterCard, and Care Credit. If your check is returned for any reason, you will be responsible for a returned check fee of $35, in addition to the original portion due. Restitution must be made within 20 days, or further legal action will be taken.

If a minor is brought in for treatment, the adult seeking the treatment is responsible for payment, regardless of who carries the insurance policy or who has custody.

Initial _____

CONSENT TO DENTAL TREATMENT, PHOTOGRAPHY AND STUDY MODELS

Undersigned hereby authorizes Nykiel Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental needs. I also authorize Nykiel Dentistry to perform all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Nykiel Dentistry choose and employ such assistance as they deem fit. I understand the use of anesthetic agents embodies a certain risk. I also authorize release of any information concerning my (or my child's) health care, medical history advice and treatment to another dentist/doctor or if applicable, an insurance company.

In connection with dental services which I am receiving from Nykiel Dentistry, I agree and consent to allow the photographs taken and any study models made before, during and after completion of my dental treatments to be used for dental records, research, education, public relations, patient counseling, marketing or other purposes.

Initial _____

INSURANCE POLICIES AND FINANCIAL AGREEMENT

As a courtesy, we will file all insurance claims for you for covered services and are happy to help you maximize your insurance benefits. We will need a copy of your current insurance card, and you are required to pay your estimated patient portion and deductibles at the time of your service.

Undersigned hereby understands that verification of insurance does not guarantee payment. Payment is subject to review by the insurance company and is determined upon the actual receipt of the claims by the insurance company. Nykiel Dentistry will initiate and file insurance claims on my behalf at no additional cost. If the insurance carrier has not responded or denies payment within 45 days of the date of the service, the entire fee for the service is due and payable by the account holder. Any remaining balance regardless of the amount of the insurance payment is my responsibility, and it is my responsibility to contact my insurance company to dispute any denial or nonpayment issues.

I hereby authorize payment directly to the above dental practice for the surgical and or dental benefits, if any, otherwise payable to me for services as described above but will not exceed the benefits provided for covered services.

I understand that any service performed for my dependent or me by Nykiel Dentistry is my personal financial responsibility, due and payable at the time of services rendered unless financial arrangements have been made. I further understand that in the event of default, I promise to pay legal interest and indebtedness. I, the insured/dependent, have read the above and understand the policies regarding office financial and insurance policies/I agree to comply with all policies and agree to be responsible for payment of all services provided.

_____ _____

Patient/Guardian Signature Date Witness Signature Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please *print* name of Patient Please *sign* Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer Christina Mincey Digitally signed by Christina Mincey Date: 2019.06.20 15:39:25 -04'00'