Richard J. Nykiel, D.D.S., P.C.
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Aesthetic and Implant Dentistry

WELCOME *to our dental office. We look forward to meeting you and to many years of teamwork in caring for your dental health needs.*

Please take a moment to read and fill out the attached forms, which will assist us in providing the utmost in care for you. If your medical doctor has advised you to premedicate prior to dental treatment, please inform us.

We would also like copies of any current x-rays from your current or previous dentist. You can request the records yourself or we can call for you. In some cases, you are required to sign a release form in order to have the record released.

We have included a HIPAA/Notice of Privacy Practices consent form. A full copy of such practices is on display in our office or on our website, nykieldentistry.com. Please complete and sign all enclosed forms and return them when you come in for your appointment. You may also fax or email them prior to your appointment date. Our email address is nykieldentistry@securedds.com and our fax number is (734)676.6646.

Please refer to the enclosed ***financial policy*** *so that you fully understand what our financial expectations are; as well as our* ***cancellation/missed appointment policies*** *are.*

THANK YOU *for your cooperation. We are excited that you have chosen our office to care for your dental healthcare. If you have any questions, please feel free to contact us. Again...* ***WELCOME****, and we look forward to your first visit!*

REGISTRATION

Patient's Last Name ______________________ First ______________________ MI __________

I prefer to be called ______________________ Birth Date ______ / ______ / ______ Age ______ Sex M / F

Social Security # ______ / ______ / ______ Driver's License # ______________________ State Issued __________

Home Address ____

City ______________________ State __________ Zip __________

Home Phone: (________) ________ - ________ Work Phone: (______) ________ - ________ Cell: (________) ________ - ________

E-Mail ______________________ Preferred form of communication: ☐ email ☐ text ☐ phone

By providing my email and text I am giving the office of Dr. Richard Nykiel permission to contact me via email, text or by phone for the purposes of meeting my dental needs and any necessary communication.

Employer ______________ Address ______________ Occupation ______________

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

Spouse's Name ______________________ Spouse's Occupation ______________________

ACCOUNT INFORMATION

Person Responsible for Account (If different than patient):

Last Name ______________________ First ______________________ MI __________

Relationship to Patient ______________________ Birth Date ____/____/____ Age ________ Sex M / F

Social Security #_____ /_____ / _____ Driver's License #______________________ State Issued__________

Home Address ____

City ______________________ State __________ Zip__________

Home Phone: (________)_______ -__________ Work Phone: (_____)_______ -__________ Cell: (________)_______ -__________

E-Mail ______________________ Preferred form of communication: ☐ email ☐ text ☐ phone

Employer ______________________ Occupation______________________

Employer's Address ____

DENTAL INSURANCE INFORMATION

Insurance Carrier ______________________ Customer Service # ______________________

Any additional Insurance coverage:

Relationship to patient ______________ DOB: ______________ Social Security # ______________

Employer ______________________ Group # ______________________

Insurance Carrier ______________________ Customer Service # ______________________

HEALTH HISTORY

Physicians' Name ______________________ Phone # ______________________

MEDICAL

1. Are you in good health? ______________________ ☐ YES ☐ NO
   ASA ______________
2. Has there been any change in your general health within the past year? ______________ ☐ YES ☐ NO
3. Date of last physical examination? ______________________
4. Are you under the care of a physician? ______________________ ☐ YES ☐ NO
5. Have you ever had any serious illness, operation, or hospitalization? ______________ ☐ YES ☐ NO
   ____ ☐ YES ☐ NO
6. Are you taking any drugs or medication? ______________________ ☐ YES ☐ NO
7. List type amount and frequency if so ______________________ ☐ YES ☐ NO
   ____
8. Are you using any recreational drugs? ______________________ ☐ YES ☐ NO
9. Are you taking any over the counter drugs? ______________________ ☐ YES ☐ NO

10. Are you sensitive or allergic to any medication? ______ ☐ YES ☐ NO

☐ Penicillin ☐ Sulfa ☐ Codeine/other ☐ Narcotic ☐ Aspirin ☐ Barbiturates ☐ Iodine ☐ other ______

Do you have or have you had any of the following: (Circle known conditions) Other ______

Aids or HIV	Rheumatic Fever	Arthritis	Diabetes
Anemia	Blood Diseases______	Head Injuries	Epilepsy
Artificial Joints	Sinus Trouble	Stomach Ulcers Stroke	Heart Murmur
Heart Ailments	Sickle Cell Anemia	Venereal Disease	Respiratory Disease
High Blood Pressure	Kidney Disease	Mental Disorders	Asthma/Hay Fever
Tumors/Growths	Tuberculosis	Radiation Treatment	Herpes
Nervous Disorders	Allergies______	Glaucoma	None of the Above
Excessive Bleeding	Fainting Spells/Seizures	Hepatitis, Jaundice or Liver Disease	
Alcohol Abuse	Drug Abuse	Fever Blisters	

If you circled any of the above conditions or added to the Other category, please give a brief explanation:

______

12. Did you use tobacco now or in the past? ______ ☐ YES ☐ NO

13. Do you wear a cardiac pacemaker? ______ ☐ YES ☐ NO

14. Have you had Heart surgery? ______ ☐ YES ☐ NO

15. Women only; a. Are you ☐ pregnant or ☐ nursing? If so, how many months?______

b. Are you taking any bisphosphonates? If so, which one? ______ How long?______

DENTAL

1. Previous Dentist______ City______ State______ Zip______

2. Was your pattern of visits ☐ regular ☐ infrequent ☐ sporadic Date of Last Dental Visit______

3. Have you been having any specific problems? ______ ☐ YES ☐ NO

Explain______

4. Have you ever been pre-medicated with antibiotics (i.e. Penicillin, etc.) before dental treatment?

______ ☐ YES ☐ NO

5. Does dental treatment make you nervous?______ ☐ YES ☐ NO

6. Do you have or have you had any of the following: (Please circle known conditions)

Bad Breath	Loosening of teeth	Bleeding gums	Cold sores	Clench your teeth	
Sensitive teeth at	Night	Day	Sweet	Temperature	
Grind your teeth at	Night	Day	Hurt	Lock Jaw	Pop

7. Have you ever had any serious trouble associated with any previous dental treatment or a bad dental experience?

☐ YES ☐ NO If yes, please describe:______

______

8. Have you ever had any of the following: ☐ Injury ☐ Oral Surgery ☐ Orthodontics ☐ Periodontics

OFFICE POLICIES

It is your responsibility to keep all appointments. If you cannot keep your schedules appointment time, in consideration of other patients in need of treatment. We kindly ask th at you give the office a 24 hour advance notice, so that we may offer your reserved time to another patient who is in need of care. Missed appointments canceled without a 24 hour advance notice are subject to a $25.00 charge.

Initial __________

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, and MasterCard. Return checks: Any bad check can and will be turned over to the justice of peace if the account is not reconciled within 20 days. You will also be responsible for a returned check fee in the amount of $35.

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.

Undersigned hereby authorizes Richard J. Nykiel DDS to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Richard J. Nykiel to make a thorough diagnosis of patient's dental needs. I also authorize Dr. Nykiel to perform and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Dr. Nykiel choose and employ such assistance as he/she deems fit. I also authorize release of any information concerning my (or my child's) health care, medical history advice and treatment to another dentist of if applicable, an insurance company. I also understand the use of anesthetic agents embodies a certain risk. I understand responsibility of payment for dentist services provided in the office for myself or my dependents is mine, 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.

CONSENT TO DENTAL PHOTOGRAPHY AND STUDY MODELS

In connection with dental services which I am receiving from Richard J. Nykiel DDS, 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, 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.

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. Dr. Nykiel's office will file and initial insurance claim 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 me. Any remaining balance regardless of the amount of the insurance payment is in my responsibility, and it is my responsibility to contact my insurance company to dispute any denial, or nonpayment issues.

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

I, ____________________, understand that any service performed for my dependent or me by Dr. Nykiel or his/her office is my personal financial responsibility. If I have dental insurance I understand that it is not Dr. Nykiel's office responsibility to collect from my insurance company. 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 OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND 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: ________________

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*** for Patient / Guardian

______________________________ ______________________________

Legal Representative / Guardian | Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ______________________________

____

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

☐ First Name Only ☐ Proper Sir Name ☐ Other ____________________

PLEASE LIST ANY OTHER PARTIES 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
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

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

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email 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.

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) ____

Rachel Salyers

Signature of Privacy Officer

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