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www.nykieldentistry.com

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_____

I Prefer to be called____________________ 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

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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'