Date: ______________________
Name: _____________________
Date of Birth: ________________
Sex: ___Male ___ Female

Address: ____
City: _______________ State: _______ Zip Code: ___________
E-mail: ____

Telephone Number(s): _________________________________
Patient Employer/School: _______________________________
How did you hear about our office: ________________________

Emergency Contact
Name: ____________________ Relationship: ____________________
Telephone Number: ____________________________

Medical History

Physicians Name/Practice: _________________________
Physicians Telephone Number: ______________________

Preferred Pharmacy: ______________________________
Pharmacy Telephone Number: ______________________

Please circle any of the following conditions that you have currently or have had in the past.

HIV/AIDS
ASTHMA
BLOOD DISEASE
CANCER
CHEMICAL DEPENDENCY
CIRCULATORY PROBLEMS
DIABETES
EPILEPSY
SEVERE HEADACHES
HIGH BLOOD PRESSURE
HEPATITIS
KIDNEY DISEASE
LIVER DISEASE
PACEMAKER
RESPIRATORY DISEASE
STROKE
SWOLLEN GLANDS
THYROID PROBLEMS

Have you ever tested positive for Tuberculosis? Yes/No
Have you ever taken any bisphosphonate medication? (ex. Fosamax, Aredia, Boniva) Yes/No
Do you have artificial heart valves or congenital heart defects? Yes/No
Have you ever been diagnosed with bacterial endocarditis? Yes/No
Have you had a total joint replacement? Yes/No
Have you undergone chemotherapy or radiation treatment? Yes/No
Have you had a reaction to dental anesthetic? Yes/No

Women:
Are you pregnant? ____ Due Date: ____

Medications: ____
Allergies: ____

Dental Insurance Information (Primary)
Policy Holders Name: ______________________________
Relationship to Patient: ____________________________
Policy Holders SSN: _______________________________
Policy Holders DOB: _______________________________
Insurance Company: ______________________________
Group #: ____

Dental Insurance Information (Secondary)
Policy Holders Name: ______________________________
Relationship to Patient: ____________________________
Policy Holders SSN: _______________________________
Policy Holders DOB: _______________________________
Insurance Company: ______________________________
Group #: ____

<u>Patients are responsible for providing their current insurance information. We reserve the right to not file a claim for any patient that cannot provide this information**</u>**

Insurance Policy

We accept and file dental insurance as a courtesy to our patients. We try to know all aspects of your dental plan, however any treatment plan that we present is only an estimate and not a guarantee of benefits. <u>We do require that you pay any portion of your treatment that your insurance estimates not to pay on the day of service. After your insurance has been filed and we receive payment, you will be sent a statement for any outstanding balance owed.</u>
We will file a pre-estimate to your insurance company for larger procedures per your request. Please know that it normally takes 3-4 weeks to receive an estimate back from an insurance company.
We are only an In-Network provider for Delta Dental. We will be considered Out of Network with any other insurance company.

Assignment and Release of Insurance Benefits

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company provided and assign directly to Dr. Kristin Herring all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Dr. Kristin Herring may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for services.

Signature of Patient/Parent: __________________________
Date: _____________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I have received and/or been provided with a copy of the Notice of Privacy Practices for the office of Dr. Kristin Herring.

_________________________ _________________________
Signature of Patient/Parent Date

Authorization for Release of Information

Name: ________________________________ Date of Birth: _____________________

Dr. Kristin Herring is authorized to release protected health information about the above named patient in the following manner and/or to selected persons.

Selected person(s): (please list names and relationship)
____

______ Voicemail
______ E-mail-provide address: _________________________
______ Text-provide number: ___________________________

For e-mail and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect receive email and/or text communication as selected. ** ________ ***please initial*

_____ Results of x-rays
_____ Financial
_____ Medical
_____ Appointment Reminders

Patient Rights
-I have the right to revoke this authorization at any time.
-I may inspect or copy the protected health information to be disclosed as described in this document.
-Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
-Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
-I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by patient.

_______________________________ _________________________
Signature of Patient/Parent Date