Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

DARREN G. KOCH, D.D.S., P.A.
FAMILY AND COSMETIC DENTISTRY

RECORDS RELEASE FORM

Date: _____

Name: _____

Address: _____

_____

Phone: _____

This is a request to release my dental x-rays from the office of:

_____
_____
_____

If digital x-rays are available, please email to: info@kochdds.com

If conventional x-rays are available, please mail to the following address:

Darren G. Koch, D.D.S., P.A.
100 Parkway Office Court, Suite 204
Cary, NC 27518

Thank you for your attention to this matter.

Patient Signature: _____

Witness: _____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

Y N	Conditions
☐ ☐	Alcohol Abuse
☐ ☐	Anemia
☐ ☐	Arthritis
☐ ☐	Artificial Heart Valve
☐ ☐	Asthma
☐ ☐	Back Problems
☐ ☐	Bleeding Disorder
☐ ☐	Blood Transfusion
☐ ☐	Breathing Difficulties
☐ ☐	Cancer
☐ ☐	Chest Pain
☐ ☐	Congenital Heart Defect
☐ ☐	Diabetes
☐ ☐	Dizziness
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Fainting
☐ ☐	Fen-Phen Use
☐ ☐	Fever Blisters
☐ ☐	HIV+ AIDS
☐ ☐	Headaches (Frequent)
☐ ☐	Heart Attack

Y N	Conditions
☐ ☐	Heart Murmur
☐ ☐	Heart Surgery
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	Hepatitis C
☐ ☐	High Blood Pressure
☐ ☐	Infective Endocarditis
☐ ☐	Jaw Pain
☐ ☐	Joint Replacement
☐ ☐	Kidney Disease
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Lung Disease
☐ ☐	Mitral Valve Prolapse
☐ ☐	Nervous Disorders
☐ ☐	Organ Transplant
☐ ☐	Osteoporosis
☐ ☐	Pacemaker
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures

Y N	Conditions
☐ ☐	Sexually Transmitted Disease
☐ ☐	Sinus Problems
☐ ☐	Stroke
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Darren G. Koch, D.D.S., P.A. – Family & Cosmetic Dentistry

OFFICE POLICIES

DOCTOR AND STAFF:

- We have acquired a very personable staff, all of whom are dedicated to the concept of Preventive Dentistry – to bring the mouth to a 100% healthy condition and prevent new dental disease through regular cleanings, oral cancer screenings and check-ups.
- Our goal is to provide you, your family and friends with the very finest dental care available.
- We have found that it is not possible for us to participate in "managed care" insurance programs while maintaining the quality of care you deserve.

YOUR INITIAL VISIT:

- Your first visit is dedicated to the determination of your present dental condition through a well-planned series of X-rays and other diagnostic aids.
- You will then be informed of our findings and we will outline our treatment recommendations to you. It is very important to us that you understand your dental needs before the initiation of treatment.
- If you have a particular need which you would like to address first, then please let us know and every effort will be made to accommodate your request.

RADIOGRAPHS:

- As a part of the commitment to excellence, it may be necessary to make different types of X-rays to assure our patients that all aspects of their dental health have been thoroughly diagnosed and evaluated.

PERIODONTAL TREATMENT:

- At each prophylaxis appointment, a periodontal screening will be performed on all patients.
- When periodontal conditions or gum disease is found, the patient will be immediately informed.
- If periodontal treatment is suggested, you will be advised that the net, long-term result of untreated gum disease will be the loss of teeth which can be painful and disfiguring.
- Periodontal problems can recur, and may require regularly scheduled office visits in conjunction with patient oral hygiene compliance at home, to prevent the disease process from recurring.

PAYMENT POLICY:

- Payment is expected at the time services are rendered. We accept cash, check, MasterCard, VISA, Discover, American Express, or payment plans through a third-party financing company - CareCredit.
- A $25 service charge will be assessed for all checks returned due to insufficient funds.
- Patients may submit their own insurance claims or as a courtesy to our patients we will prepare and submit the insurance claim to your insurance company, however, patients should be aware that they are personally responsible for payment of their account with our office, regardless of any estimated insurance coverage.
- This office assumes no responsibility for an insurance company's failure to pay a claim either due to acts by our office or any error or omission either by this office or an agent utilized by this office in the submission/processing of those claims.
- For treatment requiring multiple visits such as crowns, bridges, veneers, and/or dentures, ½ of the fee is due at the first treatment visit and the balance is due at delivery of the restoration.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

- We reserve the right to charge a $125 missed appointment fee for cancellations with less than 24 hours' notice. For patients with a history of three or more broken appointments or late cancellations, full payment must be made in advance of the next scheduled procedure.

DELINQUENT ACCOUNTS:

- Finance charges will be applied to all past due accounts (>30 days) at a 1.5% monthly rate or 18% annual rate.
- All past due balances exceeding 90 days will be treated with necessary collection procedures.

TERMINATION:

- Should you desire to transfer your records to another office, please understand that X-ray duplicates will be made and sent. The originals will be retained as part of your permanent record with this office.
- There is a nominal processing/duplication charge of $15 for this process.
- Records cannot be transferred to another health care provider without a signed medical release.
- In the event that a patient suspends or terminates care with this office, any fees for services rendered will be due immediately.

I certify that I have read, understood, and agreed to the "Office Policies" listed above and all questions have been answered to my satisfaction.

_____ _____

PATIENT SIGNATURE DATE

Would you like a copy of this document for your records? Please circle either: **YES** or **NO**

PATIENT NUMBER

welcome

Date _____

Patient's Name _____ Date of Birth _____ ☐ Male ☐ Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence - Street _____

City _____ State ____ Zip ____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ☐ Cash ☐ Credit Card ☐

Purpose of Call _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

_____

DATE _____

Form No. T110R

REGISTRATION