Patient Information

Patient Name: _____ Date:_____
Last, First MI (Preferred Name)

Gender Male or Female (Please Circle one) Family Status: Married, Single, Widow, Other (Please Circle One)

Social Security #: _____ Birth Date:_____

Phone (Home):_____(Cell)_____(Work):_____

Email:_____

Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Mrsa or Staph

OTHER:
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ N-
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Current List of Medications: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend or relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____ _____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Edward F. Kirk, D.D.S., P.C.
1175 W Wickenburg Way Ste 1
Wickenburg, AZ 85390-2262
(928)684-5475

Welcome To Our Office

We appreciate your selection of our office to serve your dental health needs. Our goal is to provide the very best possible dentistry for our patients, so that each of you may achieve optimal dental health throughout your lifetime.

Our entire staff operates as a team and we take great pride in each staff member's training and capabilities.

Office Hours

Our regular office hours are 8:00 AM to 5:00PM Monday through Friday.

The office is closed on major holidays, as well as at times when Dr. Kirk and his staff are attending continuing education programs to keep abreast of the latest developments in dentistry. We continually strive to better serve you.

Fees and Payment Policy

In an effort to keep dental cost down, while maintaining a high level of professional care, we have established the following payment plans for the benefit of our patients.

1. *Prepayment or Payment at each visit*
2. *Visa, MasterCard, Discover, American Express or Diners Club*
3. *Financing with Dental Fee Plan or Care Credit*
4. *6, or 12 months of interest free financing available upon request through Care Credit*

Accounts with outstanding balances over 90 days will be subject to 1.5% per month. This is a true annual interest rate of 18%.

Duplicate x-rays are available upon request for fee of $25.00. Returned checks are subject to a $35.00 penalty fee.
We reserve the right to charge a minimum of $50 for appointments cancelled or broken without 48 hour advanced notice.
Initials:_____

Insurance

If you have dental insurance, as a courtesy we will help you determine the type of coverage available per your plan documents and bill your insurance company for your dental care. You are responsible for your ***TOTAL BILL***, regardless of insurance coverage.

Professional care is provided to you, our patient, and not to an insurance company. Thus, the insurance company is responsible to you, the patient, and in turn as our patient; you are responsible to Dr. Kirk. We will help in every way we can in filing your claim and handling insurance questions from our office on your behalf.

Signature:_____ Date: _____

Edward F. Kirk, D.D.S., P.C.
1175 W. Wickenburg Way Ste. 1
Wickenburg, AZ 85390
www.doctorkirk.com

To Our Patients

Welcome to our office. We hope that this information will answer questions you might have about the financial policy of our office.

Payment is expected at the time services are rendered. We accept personal checks (with proper ID) and all major credit cards.

There is a fee for the initial exam, which is $100.00 or $177.00, depending upon the diagnostic testing performed. Your insurance may or may not pay for this visit.

After Dr. Kirk has seen you and determined specifically what treatment you need, we will be happy to help with your insurance. We will attempt to contact your insurance company to find out what they will pay on your treatment and what will be your estimated co-pay.

If your insurance company indicates that they will pay us directly, we will ask that your payment (at the time of treatment) be in the amount that will not be covered by the insurance. We will bill your insurance and wait 30 days for payment. If they have not responded within that time, we will look to you for payment.

We do not have "in-house" financing. However, we DO have applications for a credit plan through Synchrony Financial called Care Credit. This plan must be approved and in place prior to your appointment.

Most of our patients are very conscientious about their accounts, but if it becomes necessary to use a collection service, all collection fees, attorney fees and interest of 18% per annum will be added to the account.

I accept financial responsibility for the service rendered to me by the staff at Dr. Edward F. Kirk D.D.S., P.C., and have read and understand the policies outlined above.

Date_____ Signature_____

I authorize the release of any information relating to this claim to my insurance carrier

Date _____ Signature_____

I authorize my insurance company to send benefit payment to Dr. Edward F. Kirk, D. D. S., P.C.

Date_____ Signature_____

Edward F. Kirk, D.D.S., P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____Email:_____

Patient Number:_____Social Security Number:_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you are giving consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Olivia I. Kirk
Telephone: 928-684-5475 Fax: 928-684-1145
Address: 1175 W. Wickenburg Way, Ste #1, Wickenburg, AZ 85390

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of the Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

EDWARD F. KIRK, D.D.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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)
