PARKWAY DENTAL

PATIENT INFORMATION

First Name: _____ **MI:**_____**Last Name:**_____
Preferred Name:_____ **Title:** ◯ None ◯ Mr. ◯ Mrs. ◯ Miss ◯ Ms. ◯ Dr.
Birth date:_____ **Social Security #:**_____**Gender:** ◯ Male ◯ Female
Cell #:_____ **Home #:** _____ **Work #:** _____ **Ext:**_____
Address:_____**City/State/Zip:**_____
Email:_____

How did you learn of our office?

◯ Friend ◯ Family ◯ Website ◯ Facebook ◯ Google Search ◯ Mail
◯ Drive-by ◯ Radio ◯ Insurance ◯ News ◯ Other:_____

Marital Status:

◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Significant Other

Appointment Preference: **On Short Notice?**

◯ None ◯ AM ◯ PM ◯ Yes ◯ No

For your convenience our office can communicate with you by text or email. It's okay for the office to:

◯ Text Me ◯ Email Me ◯ Send me appointment reminders

Patient is (select all that apply):

◯ Patient ◯ Policy Holder ◯ Responsible Party

Employed: **Student:**

◯ Full-Time ◯ Part-Time ◯ N/A ◯ Full-Time ◯ Part-Time ◯ N/A

In case of emergency, please contact:

Name: _____**Phone:**_____**Relation:**_____

Who is responsible for your account:

◯ Self ◯ Spouse ◯ Father ◯ Mother ◯ Other

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

PARKWAY DENTAL

INSURANCE INFORMATION

Do you have insurance: ◯ Yes ◯ No

Type of Insurance: ◯ Dental ◯ Medical

Employer:_____ **Insurance Company Name:**_____

ID #:_____ **Group #:**_____ **Group Name:**_____

Address:_____ **City/State/Zip:** _____

Policy Holder First Name:_____ **Policy Holder Last Name:**_____

Relation:_____ **Insured Birthdate:**_____ **Social Security #:**_____

Policy Holder Phone:_____

Policy Holder Address:_____ **City/State/Zip:**_____

Do you have SECONDARY insurance: ◯ Yes ◯ No

Type of Insurance: ◯ Dental ◯ Medical

Employer:_____ **Insurance Company Name:**_____

ID #:_____ **Group #:**_____ **Group Name:**_____

Address:_____ **City/State/Zip:** _____

Policy Holder First Name:_____ **Policy Holder Last Name:**_____

Relation:_____ **Insured Birthdate:**_____ **Social Security #:**_____

Phone:_____

Address:_____ **City/State/Zip:**_____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to this dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

PARKWAY DENTAL

MEDICAL HISTORY

Patient Name:_____ Birth Date:_____ Today's Date:_____

DENTAL HISTORY

Do you have a specific dental problem? If yes, please list.	◯Yes ◯ No	If yes_____
Do you have regular dental exams? Last visit?	◯Yes ◯ No	If yes_____
Do you brush and floss on a routine basis? How often?	◯Yes ◯ No	If yes_____
Have you had dental x-rays in the last 5 years? When?	◯Yes ◯ No	If yes_____
Any popping, clicking, or discomfort in your jaw joint?	◯Yes ◯ No	If yes_____
Have you ever had trouble following tooth removal?	◯Yes ◯ No	If yes_____
Do your gums ever bleed?	◯Yes ◯ No	If yes_____
Do you grind your teeth?	◯Yes ◯ No	If yes_____
Do you smoke or chew tobacco products?	◯Yes ◯ No	If yes_____
Have you ever thought about straightening your teeth?	◯Yes ◯ No	If yes_____
Are you interested in a brighter smile?	◯Yes ◯ No	If yes_____

MEDICAL HISTORY

Are you under a physician's care now? If yes, why?	◯Yes ◯ No	If yes_____
Has your physician ever recommended antibiotic premedication for your dental visits?	◯Yes ◯ No	If yes_____
Are you taking any medications, pills or drugs? If yes, please list.	◯Yes ◯ No	If yes_____
		_____
		_____
Have you ever taken Fosmax, Boniva, Actonel or any other medications containing bisphosphonates?	◯Yes ◯ No	If yes_____
Do you use controlled substances?	◯Yes ◯ No	If yes_____

WOMEN: Are you…

◯Pregnant/Trying to get pregnant? ◯Nursing? ◯Taking oral contraceptives?

ALLERGIES

Are you allergic to any of the following?

◯Aspirin ◯Penicilin ◯Codeine ◯Acrylic
◯Metal ◯Latex ◯Sulfa Drugs ◯Local Anesthetics
◯Other:_____

Do you have or have you had, any of the following?

AIDS/HIV Positive	◯Yes ◯No	Chemotherapy	◯Yes ◯No	Drug Addiction	◯Yes ◯No	Cold Sores/Fever Blisters	◯Yes ◯No
Artificial Joint	◯Yes ◯No	Low Blood Pressure	◯Yes ◯No	Radiation	◯Yes ◯No	Hepatitis A	◯Yes ◯No
Artificial Heart Valve	◯Yes ◯No	Epilepsy or Seizers	◯Yes ◯No	Heart Attack/Failure	◯Yes ◯No	Tuberculosis	◯Yes ◯No
Irregular Heartbeat	◯Yes ◯No	Rheumatic Fever	◯Yes ◯No	Heart Trouble/Disease	◯Yes ◯No	Kidney Problems	◯Yes ◯No
Cancer	◯Yes ◯No	Heart Murmur	◯Yes ◯No	Hepatitis B or C	◯Yes ◯No	Excessive Bleeding	◯Yes ◯No
Stomach/Intestinal Disease	◯Yes ◯No	High Blood Pressure	◯Yes ◯No	Diabetes	◯Yes ◯No	Stroke	◯Yes ◯No
Heart Pacemaker	◯Yes ◯No	Asthma	◯Yes ◯No	Mitral Valve Prolapse	◯Yes ◯No	Thyroid Disease	◯Yes ◯No
Sleep Apnea	◯Yes ◯No	Arthritis	◯Yes ◯No	Herpes	◯Yes ◯No		

Have you ever had any serious illnesses not listed above? ◯Yes ◯ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Parkway Dental Health Professionals of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Date:_____

PARKWAY DENTAL

CONSENT TO CONTACT

Please provide the following information on how you would like the office to contact you and to whom you give access to your information.

I authorize contact from Parkway Dental to confirm my appointment, treatment and billing information via:

◯ Cell Phone ◯ Home Phone ◯ Work ◯ Email ◯ Text

Please list any other parties who can have access to your information. This includes spouse, partners, parents, step parents, grandparents, care takers and/or individuals.

Name: _____

Relationship: _____

Phone #: _____

Name: _____

Relationship: _____

Phone #: _____

Name: _____

Relationship: _____

Phone #: _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may not be able to grant your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the top of the page
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you

Example: A doctor treating you for an injury asks another doctor about your overall health condition

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date: February 19, 2025

I hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices. I may refuse to sign this acknowledgement. To obtain a paper copy I may request it from the office or the website.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

PARKWAY DENTAL

CONSENT FOR DENTAL PHOTOGRAPHY

The undersigned, do hereby authorize and consent to the use of photographs, videos and x-rays of me taken by Parkway Dental Health Professionals before, during, and after treatment. I grant them permission to reproduce, print and publish photographs taken of me in a professional publication or in the form of prints, film or slides in connection with articles and lectures dealing with the jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy which might accrue to me on account of the use of such pictures without my express consent in each instance. I do consent to the use of my photographs or images or videos or x-rays for promotional purposes including but not limited to, advertising, website, social media, publicity, commercial or display of use, patient education, and in-office promotional education for Parkway Dental Health Professionals only.

I further understand that if the photographs and/or images are used, my name or similar identifying information will not be used. No full face or comparable photos will be used without your additional express written authorization. I further acknowledge that my participation is voluntary and that I will not receive any compensation, financial or otherwise, with respect to the taking, use or publication of these photographs for any dental office publications. I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

◯ Yes ◯ No

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____

PARKWAY DENTAL

FINANCIAL POLICY

As validated by my signature on the bottom of this form, I understand and agree that:

All patient balances are due immediately at time of service. Please ask us if you are interested in learning about third party financing offered through CareCredit, which may allow you to finance your treatment in low monthly payments.

Should a balance accrue on the account, a statement will be sent and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days, interest may be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.

A returned check fee will be applied for each check payment returned to us by your bank.

Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any services that are unpaid by my insurance provider.

If there is dental insurance on the account, I understand that the office will provide a pre authorization estimate based on the dental information I have provided. Final payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.

PLEASE NOTE: WE ARE NO LONGER A PARTICIPATING PROVIDER FOR ANY MEDICARE SUPPLEMENT PLANS. You may still use Medicare plans at our office. Please check with your plan to assure that you have Out of Network Benefits. By signing this agreement you understand that you will be balance billed for anything that your plan does not allow.

WE ARE NOT A PROVIDER FOR ANY STATE FUNDED DENTAL PLANS AND ARE UNABLE TO BILL TO THEM.

Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included in the total.

Estimates do not take into consideration any money that was billed toward my financial maximum or frequency limits that may have been used at other dental offices.

A submission to my insurance provider will be sent to determine an approximate final investment. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the predeterminations. Predeterminations from my insurance provider(s) are NOT a guarantee of payment.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The office will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

X_____ Today's Date:_____

Patient Name:_____ Birth Date:_____