Jeremy C. Kiersz, DDS
Rolla Family Dentistry
1701 E. 10th Street
Rolla, MO 65401
(573) 364-1599

Patient Information

Today's Date_____

(Please Print)

Name _____
First MI Last Preferred Name

Birthdate _____ □ Male □ Female Social Security # _____

Marital Status: M / D/ S/ Sep/Widow Email _____

Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell _____

Medical History

Reason for today's visit _____ Date of last dental exam _____

History of Periodontal Treatment? (Any gum treatment or surgeries) □ No □Yes

Tobacco Use? □ No □Yes

Primary Care Physician's Name _____ Phone # _____

(Women) Are you pregnant? □No □Yes If yes, Due date _____

Are you nursing? □ No □Yes taking birth control pills □ No □Yes

Are you allergic to any of the following?

□ Amoxicillin Allergy	□ Codeine Allergy	□ Dye Allergy	□ Erythromycin Allergy
□ Latex Allergy	□ Local Anesthetics	□ Metal	□ Penicillin Allergy
□ Septra Allergy	□ Sulfa Allergy	□ Vicodin Allergy	

□ Other _____

Do you have a history of the following? Please check each box.

□ Aids	□Circulatory Problems	□ Hemophilia	□ Respiratory Disease
□ Arthritis	□ Cortisone Treatment	□ Hepatitis	□ Rheumatic Fever
□ Art. Heart Valves	□ Cough Up Blood	□ High Blood Pressure	□ Rheumatism
□ Artificial Joints	□ Diabetes	□ HIV Positive	□ Shortness of Breath
□ Asthma	□ Epilepsy	□ Kidney Disease	□ Stroke
□ Autism	□ Glaucoma	□ Liver Disease	□ Thyroid
□ Blood Disease	□ Headaches	□ Mitral Valve Prolapse	□ Tuberculosis
□ Cancer	□ Heart Murmur	□ Pacemaker	□ Ulcers
□ Chemotherapy	□ Heart Problems	□ Radiation Treatment	□ Venereal Disease

Please list all medications you are currently taking:

List any surgeries you have had in the past 2 years:

How did you hear about us? _____

Responsible Party (If minor)

Name of parent/guardian accompanying patient today_____
Relationship to patient _____ Social Security # _____Birthdate _____
Address _____ City _____ State _____ Zip_____
Home Phone # _____ Name of employer _____ Work Phone#_____
In case of emergency contact _____ Phone # _____

Insurance Information

Name of policyholder _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Policy ID # _____
Address _____ City _____ State _____ Zip _____
Name of Employer _____ Phone _____ Work _____
Name of Insurance Co. _____ Insurance Phone _____
Insurance address _____ City _____ State _____ Zip _____

Do you have additional insurance? ☐ No ☐ Yes If yes, please complete the following:

Name of policyholder _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Policy ID # _____
Address _____ City _____ State _____ Zip _____
Name of Employer _____ Phone _____ Work _____
Name of Insurance Co. _____ Insurance Phone _____
Insurance address _____ City _____ State _____ Zip _____

I certify that I have read and understand the above information to the best of my knowledge. *The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.* ***I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.***

_____

Signature of Patient/Parent/Guardian

Rolla Family Dentistry

1701 E. 10th Street, Rolla, MO 65401
(573) 364-1599

Thank you for choosing Rolla Family Dentistry. Our mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Debit Card, Visa, MasterCard, American Express or Discover Card

- NO INTEREST Payment Plans from Care Credit
  - Allow you to pay over time with **NO INTEREST**
  - Convenient, low monthly payment plans also available
  - No annual fee or prepayment

As a courtesy, we will gladly file your insurance with your insurance company. However, all charges are the responsibility of the patient or guardian.

If we have not received payment from your insurance company within 60 days of filing, you will be sent a statement to pay the balance. When the balance is zero, we will send you a completed claim form to file to your insurance company.

If we are unable to verify your insurance coverage while you are in the office, you are required to pay the entire amount and we will give you a claim form to file to your insurance company.

No one likes surprises at the end of a dental appointment. If you have any questions regarding your treatment or payment obligations, please ask to speak to the doctor or to a front desk person.

☐ **I do not have dental insurance and I agree to pay for any and all treatment IN FULL on the day of service.**

☐ **I have dental insurance and am responsible for paying my estimated portion on the day services are rendered.**

I have read the above and understand the contents

Patient, Parent or Guardian Signature **Date**

Dental Information Release Form

&

HIPAA Release Form

Name: _____ Date: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records, examination rendered to me, and financial information. This information may be released to:

☐ Spouse: _____

☐ Child(ren): _____

☐ Other: _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: ☐ my home ☐ my work ☐ my cell _____

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____, between (time) _____

Signed: _____ Date: _____

Rolla Family Dentistry Financial Agreement

I have the financial responsibility to pay for services at Rolla Family Dentistry. I understand that my insurance determines the fees and may provide coverage for these services, but I am responsible to pay for all fees associated with evaluation and treatment if they do not pay. If Rolla Family Dentistry participates with your insurance plan, Rolla Family Dentistry will file your insurance for you with any copay/deductible due from you to be paid at the time of service. I will be responsible for payment of my annual insurance deductible, co-insurance and co-pays as required by my insurance plan. If Rolla Family Dentistry does not participate with my insurance plan, I understand that I am financially responsible to pay for all charges and understand that Rolla Family Dentistry will ask for payment in full at the time of service and file my insurance as a courtesy with any reimbursement sent to you.

Initials: _____

I agree to allow information to be forwarded to allow payment. I request that payment under my dental insurance plan be made to Rolla Family Dentistry or the provider named on the bills for services furnished to me and authorize Rolla Family Dentistry to release to the Social Security Administration, insurance clearinghouses or insurance companies any information needed to allow this claim to be paid. I permit a copy of this authorization to be used in place of the original.

Initials: _____

I assign all insurance payments to Rolla Family Dentistry. I assign all payments for services at Rolla Family Dentistry, including private insurance and any other dental plan to Rolla Family Dentistry. If my insurance sends me payment for services at Rolla Family Dentistry, I agree to endorse the check and send it along with a copy of the explanation of benefits to Rolla Family Dentistry immediately. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Initials: _____

Non-covered services are my responsibility to pay. Certain dental plans may not cover some exams or services. Those non-covered services will be my responsibility to pay. Rolla Family Dentistry can assist, but I understand that I am responsible for knowing the specifics of my dental insurance coverage. Please remember that your insurance company determines which services are covered, not Rolla Family Dentistry.

Initials: _____

I am responsible to know my insurance plan. I understand that it is my responsibility to understand my insurance policy's provisions including what services are covered, the need for referral, the yearly maximum, the deductible, the co-insurance or co-payments that may apply. I understand that co-payments and co-insurance are due at the time of service. I understand it is my responsibility to update Rolla Family Dentistry of any changes to my insurance.

Initials: _____

I am responsible to update insurance information with Rolla Family Dentistry. I will bring my current insurance card for each visit, and if I fail to update information, I will be responsible to pay any outstanding balance not covered by a new insurance plan.

Initials: _____

If my check has insufficient funds, I agree to pay a $25 fee and will be expected to pay with a valid form of payment and not a check. Payment can then be made with cash, credit or debit card.

Initials: _____

If I do not show up for my scheduled visit without calling at least a day in advance, I agree to pay a $25 fee.

Initials: _____

Financial responsibility for minors: Adults accompanying children or requesting services are responsible for payment, regardless of who has custody or who carries the insurance on the patient.

Initials: _____

Acknowledgment of Rolla Family Dentistry financial agreement and patient financial responsibility

Signature: _____ Date: _____

Name (print): _____