Tyrone Family Dentistry
Dr. Anh Khieu

TYRONE FAMILY DENTISTRY
TAKING FEAR OUT OF DENTISTRY
ARTISTRY • INTEGRITY • PASSION

WWW.DENTISTTYRONE.COM
Tel: (678) 788-8050
1522 HWY. 74
TYRONE, GA 30290

PATIENT INFORMATION

Date: ☐ NEW PATIENT ☐ UPDATE

Patient:
LAST FIRST MI PREFERRED TITLE

☐ MALE ☐ FEMALE ☐ CHILD* ☐ STUDENT** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐ FULL-TIME ☐ PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:
ADDRESS LINE 1
ADDRESS LINE 2
CITY ST ZIP CODE

HOME:
CELL:
OTHER:
PAGER:
FAX:

E-Mail:

Referral? ☐ Yes ☐ No **How did you hear about us?**

MEDICAL HISTORY UPDATES

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Would you like to have a Velscope oral cancer screening? ☐ Y ☐ N
**Note: Some insurance plans do not cover this service; please check your plan documents for details.*

☐Y ☐N Under a physician's care now?
☐Y ☐N Any hospitalization in the past 5 years?
☐Y ☐N Any serious illnesses/surgeries?
☐Y ☐N Use tobacco in any form? If Yes, Type:
☐Y ☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ☐Y ☐N Currently nursing? ☐Y ☐N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Y ☐ N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe:

Tyrone Family Dentistry
Dr. Anh Khieu

TYRONE FAMILY DENTISTRY
TAKING FEAR OUT OF DENTISTRY
ARTISTRY • INTEGRITY • PASSION

WWW.DENTISTTYRONE.COM
Tel: (678) 788-8050
1522 HWY. 74
TYRONE, GA 30290

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ACID REFLUX	☐ BULIMIA	☐ HEARING PROBLEMS	☐ PSYCHIATRIC TREATMENT
☐ ADHD	☐ CANCER/MALIGNANCY	☐ HEART ATTACK	☐ RADIATION/CHEMO
☐ AIDS/HIV	☐ CEREBRAL PALSY	☐ HEART DISEASE	☐ RESPIRATORY DISEASE
☐ ANEMIA	☐ CHEMICAL DEPENDENCY	☐ HEART MURMUR	☐ RHEUMATIC FEVER
☐ ANOREXIA	☐ CHICKEN POX	☐ HEPATITIS	☐ SINUS PROBLEMS
☐ ANXIETY	☐ CONVULSIONS	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ ARTIFICIAL HEART VALVE	☐ DEPRESSION	☐ KIDNEY DISEASE	☐ THYROID CONDITION
☐ ARTIFICIAL JOINTS	☐ DIABETES	☐ LIVER PROBLEMS	☐ TUBERCULOSIS
☐ ARTHRITIS	☐ DIZZINESS/FAINTING	☐ MITRAL VALVE PROLAPSE	☐ ULCERS
☐ ASTHMA	☐ EPILEPSY/SEIZURES	☐ MONONUCLEOSIS	☐ VENEREAL DISEASE
☐ AUTISM/ASPERGER'S	☐ FREQUENT EAR INFECTIONS	☐ PACEMAKER	
☐ BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐ OTHER – PLEASE LIST:	

ALLERGIES/ALLERGIC REACTIONS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ ASPIRIN	☐ CODEINE	☐ LACTOSE INTOLERANCE	☐ SLEEPING PILLS	☐ NONE
☐ ANESTHETIC – LOCAL	☐ DAIRY	☐ METAL SENSITIVITY	☐ SULFA DRUGS	
☐ BARBITURATES	☐ LATEX	☐ NITROUS OXIDE SEDATION	☐ PENICILLIN/OTHER ANTIBIOTICS	
☐ OTHER – PLEASE LIST				

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS	☐ ANTIHISTAMINES/ALLERGY	☐ DAILY ASPIRIN	☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS	☐ CANCER/CHEMO MEDICATIONS	☐ CORTISONE/STEROIDS	☐ HEART MEDICATION/DIGITALIS
☐ INSULIN	☐ NITROGLYCERIN	☐ ORAL CONTRACEPTIVES	☐ OSTEOPOROSIS MEDICATIONS
☐ RECREATIONAL DRUGS	☐ THYROID MEDICATIONS	☐ TRANQUILIZERS	☐ OTHER DIABETIC MEDICATIONS
☐ OTC DRUGS/ MEDICATIONS (PLEASE LIST BELOW)	☐ OTHER (PLEASE LIST BELOW)		

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: DATE:

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

Tyrone Family Dentistry
Dr. Anh Khieu

TYRONE FAMILY DENTISTRY
TAKING FEAR OUT OF DENTISTRY
ARTISTRY • INTEGRITY • PASSION

WWW.DENTISTTYRONE.COM
Tel: (678) 788-8050

1522 HWY. 74
TYRONE, GA 30290

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name: **Date:**

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ GUARDIAN ☐ OTHER(PLEASE EXPLAIN)

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by Dr. Anh Khieu, DMD:

☐ Cell phone: ☐ Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

I give permission for Dr. Anh Khieu, DMD to disclose their identity when calling; to anyone who may answer my phone. ☐Y ☐N ☐ Other (Please explain)

I grant permission for Dr. Anh Khieu, DMD to leave a message on:

☐ Home phone ☐ Work Phone
☐ Cell Phone ☐ With any person who may answer when calling the home or cell phone
☐ None of the above (Please explain)

I would like the following person(s) to have access to my personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

NAME:_____ RELATION:_____

NAME:_____ RELATION:_____

NAME:_____ RELATION:_____

Tyrone Family Dentistry
Dr. Anh Khieu

TYRONE FAMILY DENTISTRY
TAKING FEAR OUT OF DENTISTRY
ARTISTRY • INTEGRITY • PASSION

WWW.DENTISTTYRONE.COM
Tel: (678) 788-8050
1522 HWY. 74
TYRONE, GA 30290

INSURANCE PROTOCOL

As a courtesy to our patients, we will assist you in obtaining the maximum benefit from your insurance plan. We work with several insurance companies but have found that there are many misconceptions about dental insurance. Listed below are several things that will help you to better understand insurance plans/coverage as it can be quite confusing:

- Dental insurance benefits pay based on the premium paid by you or your employer. Plans with higher premiums generally pay more of the portion of your dental care and have fewer exclusions and waiting periods.
- Dental benefits help defray the costs of dental care and require you to pay the portion of the fee that insurance does not cover. This is called your co-payment.
- Dental insurance policies restrict payment for some services, use restricted fee schedules and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on premiums paid for insurance.

The relationship that you have with your insurance company is **between you and your insurance company**. It is your responsibility to know what your plan **covers and does not cover**. However, as a courtesy to you we will:

- File your insurance claim(s) within twenty four (24) hours of your visit and request that reimbursement be made to us. Whenever possible we will file your claim(s) electronically for a faster turn-around time.
- Follow the American Dental Association's guidelines for coding procedures and filing insurance claims.
- Estimate the amount of monies that your insurance SHOULD pay at the time of your appointment. This is an ESTIMATE only and can change. Many times insurance companies downgrade procedure codes after the review process of the claim. In this case, you will be responsible for the difference after their review is complete.
- Coordinate benefits based on primary insurance benefits only. Once primary payment has been made, a secondary claim will be created for patient reimbursement.

ASSIGNMENT OF BENEFITS:
I hereby assign all dental benefits to which I am entitled to Tyrone Family Dentistry. I also authorize and direct my insurance carrier(s) to issue payment checks directly to Tyrone Family Dentistry for services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that Tyrone Family Dentistry will provide me with an estimate of insurance coverage but it is just that – an estimate. Payment(s) of dental claims are not guaranteed by any insurance company and is based on eligibility and policy coverage at the time a claim is submitted. I understand that I am responsible for any amount not covered by insurance and I agree to pay any balance due in a timely matter. I further understand that fees are due and payable on the date that the services are rendered and agree to pay such charges incurred in full immediately upon presentation of the appropriate statement.

_____ _____
Responsible Party Signature Date

Appointments and Cancellations Policy

When we make your appointment, we are reserving a room for your particular needs because we understand that your time is valuable. We ask that if you must change an appointment, please give us at least a 48 business hour notice over the phone. (I.E. if your appointment is Monday we must here from you by Wednesday by your appointment time). We will hold your appointment for 10 minutes beyond your scheduled time, however late arrival can result in rescheduling. Int _____

There is a charge for not showing up for scheduled appointments*. Repeated cancellations or missed appointments will result in loss of future appointment reservation privileges.*

All appointment reservations will require a reservation fee, except routine cleanings. The reservation fee is $55 per hour. This fee will be deducted from your estimated out of pocket expense on date of service. If the appointment is forfeited the fee will be kept as a broken appointment fee. Int _____

All children 16 and under are required to have a parent present throughout the duration of their appointment in office. If in the event a parent is not present or leaves, treatment for that day will not be rendered. A broken appointment fee of $55 per hour will be assessed. Int _____

I have been given the opportunity to read the above and have had all my questions answered. I fully understand the "Appointments and Cancellations Policy".

Name _____ Signature _____ Date _____

Tyrone Family Dentistry
Dr. Anh Khieu

TYRONE FAMILY DENTISTRY
TAKING FEAR OUT OF DENTISTRY
ARTISTRY • INTEGRITY • PASSION

WWW.DENTISTTYRONE.COM
Tel: (678) 788-8050
1522 HWY. 74
TYRONE, GA 30290

FINANCIAL POLICY

This statement is to inform you of our financial policy. Financial arrangements are both necessary and beneficial to maintaining a sound professional relationship. We are committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with our patient, not with the insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a part of that contract. While we strive to provide you with the most to the penny coordination of benefits, each plan pays different. If payment from your insurance company is not received within 30 days from date of service, you will be expected to pay the balance in full. Int _____

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, benefits MUST be verified 48 hours prior to your appointment. If benefits have not been verified, we will gladly process your claim, but the appointment will have to be paid for in advance. Int _____

Payment is due prior to services being rendered. Our office accepts cash, Master Card, Visa, Discover, American Express and Care Credit. We do not accept checks. Int _____

Balances older than 90 days may be subject to collection fees and finance. Additionally, our office will charge you for broken appointments and appointments cancelled without 48 business hours advance notice. It is vital you give our office a 48 business hour notice to avoid cancelled appointment charges (equivalent to an office visit of $55 per hour scheduled). Int _____

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

I have been given the opportunity to read the above and have had all my questions answered. I fully understand the “Financial Policy”.

_____
Print Name

_____ _____
Signature Date