KNOLLWOOD
DENTAL
GROUP, P.C.

# Broken Appointment Policy

Due to a high volume of broken appointments, there will be a charge of $50.00 for every cleaning appointment cancelled without a 24 hour notice. The charge for treatment appointments cancelled without a 24 hour notice will be up to Dr. Brown's discretion, depending on the length of appointment. The notice must be on a business day and **CANNOT** be left on the answering machine night before or weekend of the appointment, no exceptions! We are sorry for any inconvenience; So please let us know if you will be unable to make your appointments in advance!

**Signature**_____

**Date** _____

5612 Cottage Hill Road ☐ Mobile, Alabama 36609

251/666-3982 ☐ Fax 251/661-9523

# KNOLLWOOD DENTAL GROUP

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement*

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

_____

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)

_____

_____

_____

_____

# KNOLLWOOD DENTAL GROUP, L.L.C.

## PATIENT INFORMATION

**(PLEASE PRINT)**

Cell Phone _____

Date _____ Home Phone _____

Patient _____
Last Name Mr./Mrs./Miss First Name Initial Preferred Name

Address _____ City _____ State _____ Zip _____

Sex [ ] M [ ] F Age _____ Birthdate _____ [ ] Single [ ] Married [ ] Widowed [ ]Divorced

If Minor give School, Grade, Parent's or Guardian's Name _____

_____

Patient SS# _____ Driver's License# _____ Number of Children _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____
City State

Spouse Name _____ Occupation _____

Spouse Employed By _____ Business Phone _____

Business Address _____ SS# _____
State

Person to contact in case of an emergency _____ Phone Number _____ Hm. Wk.

Closest relative not living with you _____
Name Address Phone

Is another member of your family, or relative a patient at our office? _____
Name

Whom may we thank for referring you to our office? _____

## INSURANCE INFORMATION

### PRIMARY COVERAGE

Insured's Name _____ Home Phone _____

Insured's Address _____ Plan# _____ Contact# _____

Insured's Company _____ SS# _____ Group# _____

Insured's Date of Birth _____

### SECONDARY COVERAGE

Insured's Name _____ Home Phone _____

Insured's Address _____ Plan# _____ Contact# _____

Insured's Company _____ SS# _____ Group# _____

Dental Insurance Patients

We welcome your insurance and will fill out all necessary forms to aid you in receiving your maximum benefits. It is customary that all deductibles be paid as well as the portion of the fee not covered by your insurance at the time of treatment. If this is done we'll be happy to wait for your insurance check. Please remember in order to process your insurance claim we ust have a signed insurance form.

Since your insurance policy is generally a contract between you and your insurance company, please be aware that you are responsible for your bill regardless of what your insurance pays.

I AGREE TO PAY ALL FEES AND WAIVE ALL RIGHT OF EXEMTION UNDER THE CONSTITUTION AND THE LAWS OF ALABAMA, OR ANY OTHER STATE AND AGREE TO PAY ALL COST OF COLLECTING THESE FEES, INCLUDING A REASONABLE COLLECTION AND/OR ATTORNEY FEES.

Signature _____

KNOLLWOOD DENTAL GROUP, P.C.

# Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, OR VISA/MASTERCARD/AMERICAN EXPRESS/DISCOVER.**
- **WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.**

***Regarding Insurance***

We may accept assignment of insurance benefits, provided we are able to confirm coverage. However, we do require that the appropriate % not covered by your insurance be paid at time of service. The Balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you be pre-approved on our extended plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your credit card or the extended payment plan. All accounts that have a 60-day balance will receive an automatic service charge of 18%.

***Regarding Insurance Plans where we are a participating provider***

All co-pays and deductibles are due prior to treatment. In the event your insurance coverage changes a plan where we are not participating providers, refer to above paragraph.

***Usual and Customary Rates***

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

***Minor Patients***

The adult accompanying a minor and the parents (or guardians of the minor) is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard/American Express/Discover, or payment by cash or check at time of service has been verified.

***Missed Appointments***

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

***Arbitration***

We reserve the right to submit to arbitration any dispute which might arise with regard to our services.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, and understand and agree to, this Financial Policy.

x _____ _____

Signature of Patient or Responsible Party  Date

# HEALTH HISTORY

| | | YES | NO |
|---|---|---|---|
| 1. | Do you have pain from any area of your mouth? | | |
| 2. | Are you in good health? | | |
| 3. | My last physical examination was on _____ | | |
| 4. | Are you now under the care of a physician? | | |
| | Physicians Name _____ | | |
| | Address _____ Phone # _____ | | |
| 5. | Have you been hospitalized or had serious illness within the past 5 years? If so, for What? | | |
| | _____ | | |
| 6. | Are you now taking any medication drugs or pills? _____ | | |
| | If yes, please list these drugs, and for what treatment: _____ | | |
| | _____ | | |

7. Are you allergic or have you reacted adversely to any of the following medications (please circle if yes? What were your reactions?

_____

| | | | |
|---|---|---|---|
| Aspirin | Nitrous Oxide | Valium | Penicillin |
| Darvon | Erythromycin | Scopolamaine | Other Antibiotics |
| Codeine | Tetracycline | Local Anesthetic | (Novacaine or Xylocaine) |
| Demerol | Percodan | Nembutal/Seconal | (Sleeping Pills) |

| | | | |
|---|---|---|---|
| 8. | Are you aware of being allergic to any other medication or substance? _____ | | |
| | If yes, please list: _____ | | |

9. Have you ever had: (please circle if yes) Date and Explanation _____

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Heart Trouble | | Bleeding Problems | | Kidney Disease | | Hepatitis (liver disease) | |
| Heart Attack | | Blood Transfusions | | Glaucoma | | Diabetes (sugar in blood) | |
| Heart Murmur | | Tumor or Growth | | Tuberculosis | | Anemia | |
| A Stroke | | X-Ray Treatment | | Ulcers | | Convulsions | |
| High Blood Pressure | | Arthritis | | Jaundice yellow skin, eye | | Venereal Disease | |
| Rheumatic Fever | | Asthma | | Epilepsy | | HIV Positive | |

| | | | |
|---|---|---|---|
| 10. | Has anyone in your family had diabetes? | | |
| 11. | Do you consider yourself a nervous person? | | |
| 12. | Do you smoke? _____ yes _____ no How much? _____ | | |
| 13. | Do you have any disease, condition or problem not listed above that you think we should know about? | | |
| | If yes, explain _____ | | |
| | _____ | | |

FOR WOMEN ONLY:

Are you pregnant: If yes, what month? _____

Antibiotics and any other prescribed medication may alter the effectiveness of Birth Control Pills.

I have read and understand this statement: Check yes _____ no _____

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CONSENT:

The undersigne hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered.

Signature _____ Date _____

Relationship to Patient _____

OFFICE USE

HEALTH HISTORY UPDATE

Date _____ Date _____

Changes _____ Changes _____

Signature _____ Sigature _____

OFFICE USE

| REFERRAL | | DATE | |
|---|---|---|---|
| ORTHODONTIC | _____ | PERIODONTIST | _____ |
| ENDODONTIC | _____ | ORAL SUREGEON | _____ |