KristinHerring DDS

Patient Information:

Name: _____ Today's Date: _____

Date of Birth: _____ Sex: _____ Male _____ Female

How did you hear about our office? _____

Mailing/Billing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Home Phone Number: _____

Email Address: _____

Emergency Contact: Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Dental Insurance Information (If Applicable):

Primary Dental Insurance:

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Insurance Company: _____ Group Number: _____

Subscriber/Member ID: _____ SSN: _____

Secondary Dental Insurance (If Double Coverage Applies):

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Insurance Company: _____ Group Number: _____

Subscriber/Member ID: _____ SSN: _____

Insurance and Billing Policy:

Patients are responsible for providing our office with their current dental insurance information. We accept and file dental insurance as a courtesy to our patients. Any treatment plan that we present is only an estimate based on your dental coverage and is not a guarantee of benefits.

All co-pays are required on the date of service. You will be billed for all charges that insurance does not pay. We reserve the right to refuse treatment to anyone that has an outstanding balance in our office.

We are only an In-Network provider for Delta Dental (Premier) and Delta Dental Legion insurance. We will be considered Out of Network with any other insurance.

Medical History:

Primary Care Physician/Practice: _____ Phone Number: _____

Preferred Pharmacy: _____ City: _____ Phone Number: _____

Previous Dentist/Dental Practice: _____ Phone Number: _____

Date of Last Dental Visit: _____ Are you experiencing any dental issues? YES / NO

If yes, please explain: _____

Please circle any of the following conditions/treatments that you have currently or have had in the past:

HIV/AIDS	HIGH BLOOD PRESSURE	BACTERIAL ENDOCARDITIS
ASTHMA	KIDNEY DISEASE	RADIATION TREATMENT
BLOOD DISEASE	LIVER DISEASE	CHEMOTHERAPY
CANCER	HEPATITIS	PACEMAKER
DIABETES	STROKE	SWOLLEN GLANDS
EPILEPSY	THYROID PROBLEMS	HIGH CHOLESTEROL
CIRCULATORY PROBLEMS	RESPIRATORY PROBLEMS	CHEMICAL DEPENDENCY
SEVERE HEADACHES	TUBERCULOSIS	SLEEP APNEA

Please answer ALL of the following questions to the best of your knowledge:

Have you ever had a total joint replacement surgery? YES / NO

If yes, when was your surgery? _____ Who was your orthopedic surgeon? _____

Are you required to take a dental premed/antibiotic prior to dental treatment? YES / NO

Do you have artificial heart valves or congenital heart defects? YES / NO

If yes, when was your surgery? _____ Who is/was your cardiologist? _____

Are you required to take a dental premed/antibiotic prior to dental treatment? YES / NO

Have you ever had a reaction to dental anesthetic? YES / NO

Have you ever taken any Bisphosphonates (medications for Osteoporosis)? YES / NO

Woman: Are you pregnant? YES / NO *If yes*, Due Date: _____

CURRENT MEDICATIONS (Including Supplements/Over the Counter):_____

_____

_____

ALLERGIES:_____

HIPAA Consent/Authorization for Release of Information:

I, _____, hereby understand that Dr. Kristin Herring is authorized to release my protected health information to the following person(s) in the selected manner(s).

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

PLEASE CHECK THE TYPE OF INFORMATION YOU AUTHORIZE TO BE RELEASED TO THE PERSON(S) ABOVE:

_____ Financial Information _____ Appointment Information/Reminders _____ Medical Information

_____ Results of X-Rays _____ Contact Information _____ Insurance Information

Signature of Patient/Parent/Guardian: _____ Date: _____

For email, online, and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email, online, or text communications as selected.

____ Email _____ Online ____ Text Initial Here (If any options are selected): _____

Acknowledgement of Receipt of Notice of Privacy Practices:

I have received and/or been provided with a copy of the Notice of Privacy Practices for the office of Dr. Kristin Herring. (Our Notice of Privacy Practices is provided in the waiting room.)

Signature of Patient/Parent/Guardian: _____ Date: _____

Assignment and Release of Insurance Benefits:

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company provided and assign directly to Dr. Kristin Herring all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Kristin Herring may use my health care information and may disclose such information to the above named insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for services.

Signature of Patient/Parent/Guardian: _____ Date: _____

Patient Rights:

- I have the right to revoke this authorization at any time
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by patient.

Signature of Patient/Parent/Guardian: _____ Date: _____