Patient Information

First Name: ___________________________________ MI: ____ Last Name: ____

Address: ____

City: ____ State _________ Zip Code: _____________________ Sex: M F

Home Phone: ____Cell Phone:____

Employer: ____ Work Phone:____________________________________

Occupation: ________________________________ Email Address: ____

Date of Birth___________________________________ Social Security #: ____

Marital Status: Minor Single Married Divorced Separated Widowed

Emergency Contact: ____ Phone: __________________________________

Whom may we thank for referring you? ____

Preferred Pharmacy: ____

Responsible Party (if someone other than patient)

First Name: ____________________________________ MI: ___ Last Name: ____

Address: ____

City: ____ State: __________ Zip Code: ___________________________

Home Phone: ____ Cell Phone: ____

Relationship to Patient : ____

Employer: ____ Work Phone : ____________________________________

Dental Primary Insurance Information

Name of Policy Holder: ____ Relationship to Patient: ___________________

Date of Birth: ___________________________________ Social Security #: ____

Employer: ____

Insurance Company: ____ Phone Number: _________________________________

Policy ID Number: ____ Group Number: __________________________________

Dental Secondary Insurance Information

Name of Policy Holder: ____ Relationship to Patient: __________________

Date of Birth: ____ Social Security #: ___________________________________

Employer: ____

Insurance Company: ____ Phone Number: _________________________________

Policy ID Number: ____ Group Number: ________________________________

West Knox Dentistry
Joseph W. Brakovec, D.D.S.
215 Center Park Drive, Suite 900
Knoxville, TN 37922
PHONE: (865) 966-0500

Effective April 14, 2003, Federal Regulations required healthcare providers not to give any kind of information to any person other than you, the patient, without your prior permission. This includes not giving information to your spouse, parent, other household members, etc., even when they call or come in to West Knox Dentistry on your behalf or at your request unless you have given us permission to talk to them.

Please tell us how we may contact you and to whom we may disclose your health, financial and scheduling information.

Home Phone ________________________________Work Phone ___________________________________

Cell Phone __________________________________Alternate Phone _________________________________

Please check one.

_____ I do not want information released to anyone other than myself.

_____ No restrictions speak with whom ever necessary on my behalf.

_____ Only speak with person(s) listed below:

____________________________________Relationship_________________________

____________________________________Relationship_________________________

____________________________________Relationship_________________________

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to West Knox Dentistry.

I understand that authorizing the disclosure of this health information is voluntary, and I may revoke this authorization at anytime. I need not sign this form in order to assure treatment.

_____________________________________ ______________________________
Signature of Patient or Guardian Date

______________________________________ ______________________________
Patient Name (please print) Date of Birth

WEST KNOX DENTISTRY PAYMENT AGREEMENT

This office recognizes the high cost of today's health care and wishes to do all it can to help and contain these costs. We feel that you will want to do all you can also. Therefore, we ask you to read the following and acknowledge your approval and agreement by signing your name at the bottom of the page.

1. **Payment is due at the time services are performed.** Our office accepts cash, personal checks, MasterCard, Visa, American Express, Discover, and debit card. Outside financing is available upon request and approval.

2. **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 you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

3. As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

4. 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.

5. We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

6. We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, or credit card at the time we provide service to you.

7. Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. **If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.**

8. We will cooperate fully with regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Signature ____ Date________________

West Knox Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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:

- o Individual refused to sign.
- o Communications barriers prohibited obtaining the acknowledgement.
- o An Emergency situation prevented us from obtaining acknowledgement.
- o Other (please specify). _____________________________________