Greg Herzberg, DDS
kencaryldentistry.com
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(303)973-5280

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: * _____ Last * _____ First ___ MI _____ Preferred Name

Title: _____ Mr/Ms/Mrs/etc **Gender:*** ○ Male ○ Female **Family Status:*** ○ Married ○ Single ○ Child ○ Other

Birth Date:* _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: * _____ Home _____ Mobile _____ Work _____ Ext **Best time to call:** _____

Address: * _____ Address 1 _____ Address 2

* * * _____ City _____ State _____-_____ Zip Code

DENTAL INSURANCE

We are happy to file your insurance for you and will send narratives on your behalf, when necessary. Be aware, that insurance benefits are negotiated between your employer and your insurance company, and can vary greatly. Therefore, payment for your treatment is ultimately your responsibility.

Name of Insured: _____ Last _____ First ___ MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Dental carrier's address and Phone #:

_____

_____

Subscriber ID# or SSN# _____

Group# _____

How did you hear about Ken Caryl Dentistry and/or Dr. Herzberg?

_____

_____

_____

Medical History

- ☐ Acid Reflux
- ☐ Allergies-animals
- ☐ Amoxicillin
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Aspirin Allergy
- ☐ Asthma
- ☐ Auto Immune Diseases
- ☐ Benadryl Sensitivity
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Ceclor allergy
- ☐ Cephalosporin Allerg
- ☐ Codeine Allergy
- ☐ Coumidan
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Epinephrine Sensitiv
- ☐ Erythromycin allergy
- ☐ Ethromiacin
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Food Allergies
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Latex allergy
- ☐ Levaquin
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Migraine headahes
- ☐ Mitral Valve Prolaps
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Percocet Allergy
- ☐ Pre-Medicate /Amox
- ☐ Pre-Medicate /Erythr
- ☐ Pre-Medicate /Keflex
- ☐ Radiation Treatment
- ☐ Requires Nitrous Ox
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Sulfa allergy
- ☐ Tetracycline
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Tylenol sensitivity
- ☐ Ulcers
- ☐ Venereal Disease

Do you have a medical condition that requires an antibiotic pre-medicaton for dental treatment?

***** ○ Yes ○ No

Do you have any allergies or sensitivities to medications? Please List *

_____

_____

Are you taking medications, prescriptions or homeopathic treatments? *

_____

_____

_____

Have you been hospitalized or had surgery in past two years? ○ Yes ○ No

Do you have any disease, condition or problem not listed above? (If yes, Please list)

_____

_____

Do you smoke or use tobacco? ○ Yes ○ No

WOMEN: Are you pregnant? ○ Yes ○ No

DENTAL HISTORY

Do you have regular dental check-ups? ○ Yes ○ No

Have you had any complications or anxiety during previous dental visits? Explain

_____

_____

Have you had any injuries to your skull, face, jaws, or teeth? ○ Yes ○ No

Do you have chronic headaches, neck and/shoulder pain? ○ Yes ○ No

Do your jaw joints pop, cllick, or lock, when you open your mouth? ○ Yes ○ No

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have recieved a copy of this office's Notice of Privacy Practices (found on our website, www.kencaryldentistry.com or a copy was provided in the office)

Print Name (Patient or Parent/Legal Guardian or Personal Representative): *

_____

_____

Signature of Patient (or Parent/Legal Guardian or Personal Representative):

Signature _____ **Date** _____

HIPAA RELEASE

I authorize the release of information including the diagnosis, records, examination rendered to me to be released to:

Relationship to Patient

○ Spouse ○ Child(ren) ○ Other

Name:

_____

_____

This release of infomation will remain in effect until terminated by me in writing

Office and Financial Policy

Ken Caryl Dentistry is fully committed to providing the best dental care possible. Payment with be expected in advance at the time of service for all non-contracted fees and co pays.Insurance contracts: If we have a "Participated Contract" with your Insurance carrier, we will accept assignment on all Covered Services and bill your Carrier for you. You are responsible for the co-pay, coinsurance, and deductible for all noncovered services. Insurance plans represent a contract between yourself and the insurance company. These contracts are not between the doctor and the Insurance Company. We will do our best to help you obtain benefits, but we cannot be responsible if your Carrier does not pay. Further, if a member of our staff advises you that you are fully covered or implies that you will owe nothing, it is your responsibility to contact your insurance company for verification. Therefore, it is your responsibility to make certain your carrier makes prompt payment, and to handle any disputes that may arrive. In cases in which your insurance company deems your treatment medically or dentally unnecessary and hence denies a claim, or states a claim to be unbillable to you the member, you are fully responsible for the cost of treatment completed at the full office fee. Hence, all services that are excluded by your insurance company will be charged to you at the full fee regardless of the reason stated by your insurance company. There are no refunds for any service rendered despite the outcome of completed service. If your insurance is found to not be in force on the date dental services are provided, you will be responsible for the full balance.

Third party financing options are also available, and we will be pleased to provide the necessary forms, and assist our patients with their completion.

Missed appointments: Our policy is to charge for missed appointments unless a cancellation is received at least 24 hours in advance. The charge is $75 per hour of scheduled time.

We reserve the right to dismiss any patient from our practice for inappropriate behavior in our office or on the phone.

In the event of default, Patient promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.
I acknowledge that I am responsible to pay all charges for treatment administered by Ken Caryl Dentistry as outlined above. I acknowledge that if my account is more than 90 days past due it may be placed with a collection agency for non-payment and that I will be responsible for all collection costs (28-50% additional to the balances owed), including court costs, associated attorney fees and may be subject to a monthly service charge of 1.5% interest on the unpaid balance.

*

☐ By checking this box, I acknowledge that I have read and agree to the "Office and Financial Policy" and the terms therein.

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

I consent to treatment as diagnosed by Dr. Greg Herzberg or Dr. Kayee Herzberg either preventative, restorative or emergency for patient named above. I give my consent to the use of dental anesthetics and relaxants. I acknowledge full responsibility for the payment of such services and agree to pay for them in full at the time of services. We reserve the right to charge for appointments canceled without 24 hours notice.

I realize that despite the possible complications and risks, my contemplated treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the treatment rendered. Furthermore, I attest that all of the medical and dental information I have provided is true and accurate to the best of my knowledge.

I acknowledge that I have read and agree to the policies and terms of Ken Caryl Dentistry and that I have filled out this form fully and to the completeness of my knowledge.

Signature _____ **Date** _____

Response Date: