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family dentistry

Teryl D. Edwards, DDS
Jeffrey J. Smith, DDS
Laura C. Edwards-Kurtz, DDS
Phone # (319) 232-9023

Personal Information

Today's Date: _____
Last Name: _____
First: _____ MI: _____
Birth date: _____/_____/_____
SS#: _____
Address: _____
City, State, Zip: _____
Home Phone #: _____ Wk. # _____
Cell #: _____ Email: _____

Parent Info. for Minors

Name: _____
Address (if different) _____
Phone (if different) _____

Employer Information

Employer: _____ How long? _____
Employer Phone #: _____
Occupation: _____
Status: single _____ married _____ minor _____
Spouses Name: _____
Spouses Employer: _____
Spouses birth date: __/__/__ SS#: _____
Family Members w/ birth dates: 1. _____(__/__/__)
2. _____(__/__/__) 3. _____(__/__/__)
4. _____(__/__/__) 5. _____(__/__/__)

Insurance Information

Insured's name: _____
Co. Name: _____
Phone # (___) _____
Insured's ID # _____
Group # _____
Relation: _____ Birth date: ___/___/___

Secondary Insurance: _____
Co. Name: _____
Phone # (___) _____
Insured's ID # _____ Group # _____
Relation: _____ Birth date: ___/___/___

Previous Dentist: _____
Phone #: _____

Emergency Information

Contact: _____
Relation: _____
Home Phone: _____
Work Phone: _____
Cell #: _____
Your Medical Dr.: _____

Drs. Phone #: _____

I understand the above information and guarantee this form was completd to the best of my knowledge. It is my responsibility to inform the office of any changes to this information.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

I understand that I am responsible for services rendered and also responsible for any amount not covered by my insurance policy.

_____
Signature Date

Referred By: _____

Office Use: _____

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Insurance Assignment and Release

I certify that I, and/or my dependant(s), have dental insurance coverage and assign any insurance payment directly to either Dr. Teryl Edwards and/or Dr. Jeffrey Smith of Edwards & Smith Family Dentistry. I understand that I am financially responsible for any amount not paid by my insurance. I authorize the use of my signature on all insurance submissions.

* Signature: _____ Date: _____
Patient, parent or guardian

If signed by patient representative, state relationship to patient _____

** By not signing this authorization the office will not be able to submit claims for treatment with your insurance carrier and payment will be due at the time of appointment. A print-out of any treatment would be available upon request.*

HIPAA CONSENT

I give this practice my consent to use or disclose my protected dental health information to carry out my treatment, to submit and process claims to my insurance carrier, and for referral to another care provider.

I have been informed that I may review the practice Notice of Privacy Practices (for a more complete descriptoin of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices in the practice.

I understand I have the right to request a restriction of how my protected dental health information is used. However, I also understand that the practice is not required to agree to that request. If the practice agrees to my requested restriction they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, expect for information already used or disclosed.

Signature: _____ Date: _____
Patient, parent or guardian

If signed by patient representative, state relationship to patient _____