Date.....

BYRON McKnight
dds • magd

WHERE PRECISION MEETS art

PATIENT INFO

NAME.....

NICKNAME..... ☐ MALE ☐ FEMALE

ADDRESS.....

CITY.....STATE.....ZIP.....

HOME PHONE.....CELL PHONE.....

EMAIL ADDRESS.....

OCCUPATION.....EMPLOYER.....

WORK PHONE.....DATE OF BIRTH.....AGE.....

SS#.....DL#.....

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

SPOUSE'S NAME.....

PARENT/GUARDIAN IF PATIENT IS A MINOR.....

ANY FAMILY MEMBERS THAT ARE PATIENTS HERE?.....

WHOM MAY WE THANK FOR REFERRING YOU?.....

EMERGENCY CONTACT.....

HOME PHONE.....CELL PHONE.....

RESPONSIBLE PARTY

NAME.....

RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ GUARDIAN

HOME PHONE.....CELL PHONE.....

ADDRESS.....

CITY.....STATE.....ZIP.....

EMAIL ADDRESS.....

EMPLOYER.....

WORK PHONE.....SS#.....

DENTAL INSURANCE

INSURED'S NAME..... DOB.....

ID.....GROUP # .....

INSURANCE COMPANY.....

ADDRESS.....

CITY/STATE/ZIP.....PHONE.....

EMPLOYER THAT PROVIDES INSURANCE.....

INSURED'S RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

✱ IF YOU HAVE DUAL INSURANCE, PLEASE LET US KNOW.

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please review this form completely and fill out areas which pertain to you. **All information is private and confidential.**

DENTAL HEALTH

LAST DENTIST.....CITY.....

HOW LONG.....DATE OF LAST VISIT.....

LAST CLEANING.....LAST X-RAYS.....

CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR CURRENTLY HAVE:

- ☐ MOUTH DISCOMFORT
- ☐ PREVIOUS PERIODONTAL TREATMENT
- ☐ TRENCHMOUTH OR PYORRHEA
- ☐ GUM ABSCESSES
- ☐ GUMS BLEED WHEN BRUSHING
- ☐ LOOSE OR SHIFTING TEETH
- ☐ TROUBLE IN CHEWING OR SPEAKING
- ☐ BRUISE EASILY
- ☐ GRIND OR CLENCH YOUR TEETH
- ☐ CLICKING, POPPING, OR PAIN IN JAW
- ☐ ORTHODONTIC TREATMENT
- ☐ SENSITIVE TEETH (HOT, COLD, SWEETS)
- ☐ WAKE UP WITH SORE JAW
- ☐ MOUTH ODOR OR BAD TASTE
- ☐ COLD SORES OR FEVER BLISTERS
- ☐ OTHER ORAL LESIONS
- ☐ FEAR OF DENTAL TREATMENT
- ☐ BAD DENTAL EXPERIENCE
- ☐ IMMEDIATE RELATIVES WHO LOST ALL THEIR NATURAL TEETH
- ☐ COMPLICATIONS WITH, OR FOLLOWING, PREVIOUS DENTAL OR ORAL SURGICAL TREATMENT

OTHER.....

.....

ON A SCALE OF 1 - 10, WITH 10 BEING THE HIGHEST RATING:

• HOW IMPORTANT IS YOUR DENTAL HEALTH TO YOU?

1 2 3 4 5 6 7 8 9 10

• HOW WOULD YOU RATE YOUR CURRENT DENTAL HEALTH?

1 2 3 4 5 6 7 8 9 10

WHY DID YOU LEAVE YOUR PREVIOUS DENTIST?.....

.....

AUTHORIZATION INFO

1. ALL INSURANCE BENEFITS WILL GO TO DR. McKNIGHT UNLESS TREATMENT IS PAID FOR IN FULL AT TIME OF SERVICE. INITIALS.....

2. I GIVE MY CONSENT FOR PHOTOGRAPHS OF ME TO BE USED FOR TEACHING, PRESENTATION, OR WEBSITE PURPOSES. INITIALS.....

3. AS LONG AS I AM A PATIENT HERE, MY RECORDS MAY BE SHARED WITH OTHER DOCTORS FOR CONSULTATION AND/OR REFERRAL. INITIALS.....

....

SIGNATURE (PARENT'S SIGNATURE IF PATIENT IS A MINOR) DATE

✱ Please turn over to complete **MEDICAL HEALTH** section. > > >

MEDICAL HEALTH

• HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

• LIST YOUR CURRENT PHYSICIAN(S):

..... TYPE ..... HOW LONG?.....

..... TYPE ..... HOW LONG?.....

• DATE OF LAST COMPLETE PHYSICAL EXAM..... PURPOSE.....

• FINDINGS .....

• ARE YOU AWARE OF ANY CHANGES IN YOUR GENERAL HEALTH IN THE LAST YEAR? NO YES .....

• HAVE YOU BEEN HOSPITALIZED FOR ILLNESS OR SURGERY IN THE PAST TWO YEARS? NO YES .....

• HAVE YOU BEEN UNDER A MEDICAL DOCTOR'S CARE DURING THE PAST TWO YEARS? NO YES .....

• HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT? NO YES .....

• IS THERE ANY HISTORY OF DIABETES IN YOUR FAMILY NO YES .....

• ARE YOU ON A SPECIAL OR RESTRICTED DIET OF ANY KIND? NO YES .....

• DO YOU SMOKE OR USE TOBACCO PRODUCTS (CHEW / DIP)? NO YES HOW MUCH?..... HOW LONG?.....

• LIST ALL MEDICATIONS YOU ARE NOW TAKING, AND WHAT YOU'RE TAKING THEM FOR (INCLUDE ALL OVER THE COUNTER). *FOR EXAMPLE: "LIPITOR, FOR HBP"*

.....

.....

• PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO, OR ARE UNABLE TO TAKE:

PENICILLIN	DOXYCYCLINE	CARBOCAINE	HALCION	TYLENOL	ANESTHETICS	DEMEROL	VERSED
ERYTHROMYCIN	CLINDAMYCIN	XYLOCAINE	IBUPROFEN	ASPIRIN	CODEINE	VALIUM	NALBUPHINE

OTHER .....

• INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD/CURRENTLY HAVE BY CIRCLING YES OR NO:

HEART TROUBLE..... NO YES	ARTIFICIAL JOINT (KNEE, HIP)..... NO YES	CANCERS OR TUMORS..... NO YES
HEART DISEASE OR ATTACK..... NO YES	KIDNEY/BLADDER TROUBLE..... NO YES	RADIATION TREATMENT..... NO YES
ANGINA..... NO YES	THYROID DISEASE..... NO YES	CHEMOTHERAPY..... NO YES
HIGH BLOOD PRESSURE..... NO YES	EMPHYSEMA..... NO YES	ARTHRITIS/RHEUMATISM..... NO YES
LOW BLOOD PRESSURE..... NO YES	PERSISTENT COUGH..... NO YES	GLAUCOMA..... NO YES
HEART MURMUR..... NO YES	TUBERCULOSIS..... NO YES	HEPATITIS..... NO YES
RHEUMATIC FEVER..... NO YES	ASTHMA..... NO YES	LIVER DISEASE..... NO YES
CONGENITAL HEART LESIONS..... NO YES	SINUS TROUBLES..... NO YES	JAUNDICE..... NO YES
ARTIFICIAL HEART VALVE..... NO YES	ALLERGIES OR HIVES..... NO YES	A.I.D.S. ..... NO YES
SCARLET FEVER..... NO YES	DIABETES..... NO YES	BLOOD TRANSFUSION..... NO YES
HEART PACEMAKER..... NO YES	FREQUENT THIRST AND/OR URINATION..... NO YES	DRUG OR ALCOHOL ADDICTION..... NO YES
HEART SURGERY..... NO YES	STROKE..... NO YES	VENEREAL DISEASE..... NO YES
SHORTNESS OF BREATH UPON MILD EXERTION..... NO YES	EPILEPSY OR SEIZURES..... NO YES	A NERVOUS PERSON..... NO YES
REQUIRE MORE THAN TWO PILLOWS TO SLEEP..... NO YES	FREQUENT HEADACHES..... NO YES	ULCERS..... NO YES
ANEMIA..... NO YES	FAINTING OR DIZZY SPELLS..... NO YES	PSYCHIATRIC CARE..... NO YES
SICKLE CELL DISEASE..... NO YES	UNINTENTIONAL WEIGHT GAIN/LOSS..... NO YES	

• ARE YOU TAKING, OR HAVE YOU TAKEN, BISPHOSPHONATE MEDICATIONS (FOSAMAX, ZOMETA, DIDRONEL, RECLAST, BONIVA, ACTONEL, ETC.)? NO YES

• IF FEMALE, ARE YOU: ☐ PREGNANT? ☐ TAKING BIRTH CONTROL PILLS? ☐ TAKING HORMONE MEDICATION?

• DO YOU HAVE ANY MEDICAL CONDITION/DISEASES NOT LISTED ABOVE THAT WE SHOULD KNOW ABOUT? NO YES EXPLAIN .....

.....

.....

***PLEASE READ AND SIGN:** *To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform Dr. McKnight on or before my next appointment without fail.*

....

PATIENT'S SIGNATURE DATE

Sleep Disorder Center

Sleep-Related Tests & Quizzes

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/ or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep.
1 = *slight* chance of dozing or sleeping.
2 = *moderate* chance of dozing or sleeping.
3 = *high* chance of dozing or sleeping

Situation	**Chance of Dozing or Sleeping**
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in a traffic while driving	____
Total score (add the scores up) (This is your Epworth score)	**____**

BYRON McKnight
dds - magd

FINANCIAL POLICY

We are committed to providing you the best possible care. In order to achieve these goals, we need your assistance, and our understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, and Discover.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges applied per month. Charges may also apply for broken appointments and appointments cancelled without 24 hours advance notice.

For extensive services and/or account balances, firm payment arrangements may be made through our financial manager. These payments may be made via bank draft or pre-authorized credit card payment. We will confidentially discuss your proposed dental treatment and answer any questions relating to payment and insurance.

If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. We will be happy to process your insurance claim form for proper payment of benefits. Any such request must be accompanied by and completed insurance form at each visit.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. (Please request a copy of our "Dental Insurance" summary for more information.) While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Your dental insurance is based on a contract between your employer and the insurance company. While we will attempt to estimate your dental benefits to best of our ability, this is an estimate ONLY, and should not be depended on as the final decision. Should questions arise, it is the best to contact your insurance company directly.

Notice to Dental Insurance Patients

YOU ARE RESPONSIBLE FOR YOUR BALANCE IF ANY OF THE FOLLOWING OCCURS:

- The treatment goes over my yearly maximum.
- My insurance company denies any treatment.
- I am not eligible for insurance.
- I prevent or delay payment by not complying with request for insurance forms for signatures.
- I do not complete my treatment and it results in non-payment by the insurance company.
- Lab costs are incurred due to missing appointments.
- I receive my insurance check and do not send it to your office
-

Patient Name: _____
(Please Print)

Acknowledged: _____ Date: _____
Patient Signature(or Legal Guardian)

Byron McKnight, D.D.S., M.A.G.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we make the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.
You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your healthcare information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or location) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written consent.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you request copies, we will charge you $25.00 for staff time to locate and copy your health information, plus postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other that treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Byron McKnight, D.D.S., M.A.G.D.
2856 N. Galloway Ave.
Mesquite, TX 75150
972-698-8000
smile@mcknightdental.org

Byron McKnight, D.D.S., M.A.G.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____E-mail: _____

Phone: _____Social Security Number: _____

Address: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time contacting:

Phone: 972-698-8000 Fax: 972-613-4776 E-mail: smile@mcknightdental.org

Address: 2856 N. Galloway Ave., Mesquite, TX 75150

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Information listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations, including sharing of any of my information with other physicians and/or dental personnel, as well as insurance companies and pharmacies.

Signature: _____Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance of my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Contact Information For Protected Health Information

I, _____, Date of Birth: _____, request that the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis(es) tests results, dates of service.

Please Check All That Apply

☐ **You may disclose information to my family members and/or non-family members. Please list name, phone number and relationship.**

Name	Phone Number	Relationship

☐ **You may leave Protected Health Information on my answering machine/voicemail/email.**

Phone Number: _____

Email: _____

☐ **Other:** _____

☐ **You may disclose insurance information to a referring dental office.**

Patient's Signature: _____ **Date:** _____

Patient's Printed Name	**Social Security Number**
Patient's Signature (or Guardian, if minor)	**Date**
Witness (optional)	**Date**

Notice Of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of McKnight Dental Group's Notice of Privacy Practices.

_____

Please Print Name

_____

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)**

_____

_____

_____

_____

To be retained in patient's file.

Dental Claim Form

©2012 American Dental Association

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____

Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____

Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) / 44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident	
46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) -	52a. Additional Provider ID	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____

Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID