Koch Park Dental
Martin Buchheit D.D.S.

Welcome to our Practice!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

E-mail Address: _____, Last Name: _____ First Name: _____

Preferred to be called: _____, Street Address: _____

City, State, Zip: _____ Date of Birth: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

SS#: _____, Driver's License: _____ Sex: __M____F__ Occupation: _____

Employer: _____, Address, City State, Zip _____

Emergency Contact Name: _____ Phone # : _____

Spouse's Name: _____ Occupation: _____

Spouse's Address (if different than above): _____, City, State, Zip: _____

Spouse's Employer: _____ Address, City, State, Zip: _____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: _____, Place_____ Time: _____

How did you hear about our office? Please check: _____Internet ____Patient referral ____Website ____Yellow Pages ___Mailer Other _____

If you were referral whom may we thank for their trust in us? _____

INSURANCE INFORMATION:

Primary Insurance Company : _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy Holder Name: _____:Member's ID# _____ Birth date: _____

Group# or Policy # _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement, directly to Koch Park Dental, Dr. Martin Buchheit of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged. I assigned my insurance reimbursement directly to Koch Park Dental, Dr. Martin Buchheit and agree that I am responsible for any unpaid balance should my insurance deny any reimbursement.

Date: _____ Patient's Signature: _____

CONSENT:

I hereby authorize Koch Park Dental, Dr. Martin Buchheit to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Koch Park Dental, Dr. Martin Buchheit to make a thorough diagnosis of the patient's dental needs. I also authorize Koch Park Dental, Dr. Martin Buchheit to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and not between Koch Park Dental, Dr. Martin Buchheit and your insurance company. I fully understand that it is my responsibility only for all dental treatment regardless of insurance coverage.

Patient Signature: _____ Date: _____ Dr. Signature: _____

HIPAA PRIVACY FORM
Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

Patient Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home phone [ ] my work number [ ] my cell number

_____ _____ _____

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave me a message asking for a return call

You also have my permission to text and/or e-mail me about any dental information or any dental appointments.

Signed: _____ Date: ____/____/_____

Our Financial Philosophy

It is important to us that the quality of our business services matches the quality of our dental care. We want the handling of your account, from the start to be perceived as an extension of the dental care we provide you and your family.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

So that we may file your insurance claim(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your benefits.

Regarding Insurance

We file insurance claims for all patients with insurance benefits. We accept assignment of insurance benefits however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 **days.**

WE ACCEPT CASH, CHECKS OR MASTERCARD, VISA, AMERICAN EXPRESS Ask us about EASY PAY OPTIONS
WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL which I give my consent for a credit check.

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Koch Park Dental, Dr. Martin Buchheit must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney or collection agency fees incurred by Dr. Buchheit. I give consent for any credit check to be completed by Koch Park Dental, Dr. Martin Buchheit should it be deemed necessary.**

I have read the Financial Philosophy. I understand, accept, and agree to this Financial Philosophy.

_____ _____ _____ _____

Signature of Patient or Responsible Party Date Witness for Dr. (Name of Dentist) Date

Epworth Sleepiness Scale

Name: _____Date: _____

Your Age (yrs):_____ Gender: _____F _____M

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how the following might have affected you in the past or currently affect you now.

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

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question with the above number as best as you can:

SITUATION	**CHANCE OF DOZING (0-3)**
Sitting and Reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theatre or meeting)	_____
As a Passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

THANK YOU FOR YOUR COOPERATION