KURT SOLERA D.D.S. PA
PO BOX 3237 ◆ BELLA VISTA, AR 72715
479.855.1855 FAX 479.876.1855

Patient Name: _____ Date:_____

Preferred name or nickname: _____ Marital Status:_____

Address: _____ Date of Birth:_____

City:_____ St _____ Zip _____ SSN:_____

Telephone: _____ E-mail:_____

Work phone: _____ Do you receive texts? _____

Cell phone: _____ Spouse:_____

Responsible party if other than patient :

Name: _____

Relationship to patient: _____ Marital Status:_____

Address: _____ Date of Birth:_____

City:_____ St _____ Zip _____ SSN:_____

Telephone: _____ E-mail:_____

Work phone: _____ May we texts? _____

Cell phone: _____ Spouse (if other than patient):_____

Responsible Party Employer:_____ May we call you at work?_____

Address:_____ Occupation:_____

City:_____ St _____ Zip _____

Primary Dental Insurance Company	Secondary Dental Insurance Company
Ins Co Name	Ins Co Name
Group #	Group #
Policy Holder	Policy Holder
Policy Holder DOB	Policy Holder DOB
Policy Holder Member ID	Policy Holder Member ID

Please provide the receptionist with a copy of your insurance card(s) and a photo id.

Who may we thank for referring you?_____

MEDICAL HISTORY

	Y	N	If yes, please explain
Are you under a physician's care?	☐	☐	_____
Have you had an operation or been hospitalized?	☐	☐	_____
Have you ever had a serious head or neck injury?	☐	☐	_____

Are you taking any medications? Please list _____

_____

_____

Have you ever taken Phen-Fen or Redux? ☐ ☐ _____

Do you or have you taken bone density medication? If so, which one and when? _____

_____

Are you on a special diet? _____

Do you use tobacco? Y ☐ N ☐

Women are you: ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Allergies: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Local Anesthetics ☐ Other: _____

Do you use Controlled Substances? Y ☐ N ☐ If yes, _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	Y	N		Y	N
AIDS/HIV Positive	☐	☐	Drug Addiction	☐	☐
Alzheimer's	☐	☐	Easily Winded	☐	☐
Anaphylaxis	☐	☐	Emphysema	☐	☐
Anemia	☐	☐	Epilepsy or Seizure	☐	☐
Angina	☐	☐	Excessive Bleeding	☐	☐
Arthritis/Gout	☐	☐	Excessive Thirst	☐	☐
Artificial Heart Valve	☐	☐	Fainting Spells/Dizziness	☐	☐
Artificial Joint	☐	☐	Frequent Cough	☐	☐
Asthma	☐	☐	Frequent Diarrhea	☐	☐
Blood Disease	☐	☐	Frequent Headache	☐	☐
Blood Transfusion	☐	☐	Genital Herpes	☐	☐
Breathing Problems	☐	☐	Glaucoma	☐	☐
Bruise Easily	☐	☐	Hay Fever	☐	☐
Cancer	☐	☐	Heart Attack/Failure	☐	☐
Chemotherapy	☐	☐	Heart Murmur	☐	☐
Chest Pains	☐	☐	Heart Pacemaker	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Trouble/Disease	☐	☐
Congenital Heart Disorder	☐	☐	Hemophilia	☐	☐
Convulsions	☐	☐	Hepatitis A	☐	☐
Yellow Jaundice	☐	☐	Hepatitis B or C	☐	☐
Cortisone Medicine	☐	☐	Herpes	☐	☐
Diabetes	☐	☐	High Blood Pressure	☐	☐

	Y	N		Y	N
High Cholesterol	☐	☐	Rheumatic Fever	☐	☐
Hives or Rash	☐	☐	Rheumatism	☐	☐
Hypoglycemia	☐	☐	Scarlet Fever	☐	☐
Irregular Heartbeat	☐	☐	Shingles	☐	☐
Kidney Problems	☐	☐	Sickle Cell Disease	☐	☐
Leukemia	☐	☐	Sinus Trouble	☐	☐
Liver Disease	☐	☐	Spina Bifida	☐	☐
Low Blood Pressure	☐	☐	Stomach/Intestinal Disease	☐	☐
Lung Disease	☐	☐	Stroke	☐	☐
Mitral Valve Prolapse	☐	☐	Swelling of Limbs	☐	☐
Osteoporosis	☐	☐	Thyroid Disease	☐	☐
Pain In Jaw Joints	☐	☐	Tonsillitis	☐	☐
Parathyroid	☐	☐	Tuberculosis	☐	☐
Psychiatric Care	☐	☐	Tumors or Growths	☐	☐
Radiation Treatments	☐	☐	Ulcers	☐	☐
Recent Weight Loss	☐	☐	Venereal Disease	☐	☐
Renal Dialysis	☐	☐			

Have you ever had any serious illness not listed above? _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian

Date: _____

KURT SOLERA DDS PA

PRACTICE PAYMENT POLICY

Cancellation Policy:

For failed appointments or cancellations that are not made at least 24 BUSINESS hours, a $25 cancellation fee will be charged.

Payment Options:

Insurance: As a courtesy, we process insurance claims for our patients. We do not contract with any carriers, and therefore we will be filing your claims as an **out-of-network provider**. Although we attempt to discuss this with patients before scheduling the first time, it is the insured's responsibility to let us know that he or she has insurance. The practice may or may not know what your insurance will cover and pay, but it is the patient's responsibility to know their plan, and what services and limitations apply. We will *estimate* your deductible and co-payment at the time of service, and that amount will be due on the date of service. Actual cost may vary from the estimate. The patient is responsible to pay the difference between our charges and what insurance pays. If insurance has not paid our office within 60 days of treatment, the patient is responsible to pay the unpaid amount.

Initial Payments: Payment for each visit is due at the time of treatment. We accept cash, CareCredit, Visa, MasterCard, and Discover, and checks with valid drivers license. If a particular procedure requires more than one visit, we allow the patient to pay half at the initial visit and the balance when treatment is complete.

ALL COSTS OF COLLECTIONS OF DELINQUENT ACCOUNTS IS THE RESPONSIBILITY OF THE PERSON SIGNING THIS FORM.

I understand and agree to these terms, and I assign my dental insurance payments to this office with full knowledge that this office is not in-network with my insurance.

_____ _____

Patient's signature Today's Date:

_____

Print your name

KURT SOLERA, D.D.S., PA
ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I have received or been offered a copy of this office's Notice of Privacy Practices.

_____ _____

Patient signature Date

AMBULATORY CONSENT FORM

NAME (Please Print) _____

DATE OF BIRTH: _____

I, _____, consent to medical examination, laboratory procedures and other studies ordered by Kurt Solera, D.D.S. or other healthcare providers under Dr. Solera's supervision, upon my approval and scheduling of those procedures.

I authorize Kurt Solera, D.D.S., P.A. or any employee or contract laborer authorized by Dr. Solera to release any medical or other information necessary to process insurance claims for myself or any dependent covered by my and/or my spouse's insurance. I authorize this information to be released to my insurance carrier or benefit administrator, for purposes of processing claims or precertifications or verifying benefits should this be a requirement for claims processing. I authorize direct payment of insurance to Kurt Solera,. DDS PA.

You may discuss my medical information with the following individual(s) as my personal representative(s). (Please list the name of any person with whom you wish us to be able to discuss your treatment, care and personal information. This could be a spouse, your child, or a parent. If you wish to have more than two personal representatives, please notify office attendant for another form.)

_____ _____

Name of 1st personal representative Relation to patient

_____ _____

Name of 2nd personal representative Relation to patient

A copy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Insured (or Authorized Person) Date

KURT SOLERA DDS PA
NOTICE OF PRIVACY PRACTICES

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 and make it available to you in writing about our privacy practices, our legal duties, and your rights concerning your health information. This notice takes effect October 1 2003 and remains in effect until we replace it. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

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

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

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

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

Required By Law: We will use/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.

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 counter-intelligence, and other national security activities We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use/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 that you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain from our office a form to request access. We will charge you a reasonable cost based fee for expenses such as copes and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies we will charge you $0.75 for each page and $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format.

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 than treatment, payment, health care 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 those 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).

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

Encryption Policy: As a rule we do not initiate communication with patients via e-mail. You may e-mail electronic protected health information to this office AT YOUR RISK. We will respond to your e-mail only if, YOU AGREE TO RECEIVE AN UNENCRYPTED E-MAIL RESPONSE and we receive a request in writing from you. We do not encrypt e-mail and the messages may not be secure.

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 COMPLAINTS AND OTHER NOTICES

You may authorize us to use/disclose your information for purposes or to individuals other than those included in this document, and you may revoke that authorization at any time. Authorization and revocation of such authorization must be in writing.

Questions and Complaints should be directed to the Practice Manager of Kurt Solera, D.D.S. PA through one of the following means:

Telephone: 479.855.1855
Fax: 479.876.1855
Address: P.O. Box 3237, Bella Vista, Arkansas 72715