Tyler Periodontics

Dr. Kayleigh E. Temple & Dr. John E. Adcock

THE FIRST APPOINTMENT

Thank you for scheduling an appointment in our office. Attached you will find a "Patient Information & Health History" Sheet. Please complete the entire form and make a list of any prescription medications you are currently taking and bring this to your first visit. The initial visit is _____ and patients are required to pay 100% of the initial visit fee regardless of insurance coverage. We accept Visa, Mastercard, Discover, and personal checks. Occasionally, there is a need to take x-rays, which are at an additional charge.

The initial visit involves a comprehensive evaluation of your periodontal needs which will take about one hour. The initial diagnosis and treatment plan will be explained during the first visit and you will be provided an opportunity to ask questions (some even find it helpful to bring a written list of questions). You will be given a written copy of the treatment plan, which will include the fees for any recommended treatment.

If you have dental insurance, bring your insurance card or information to your appointment. Our computer will generate a claim and your insurance company may make a payment directly to you. If additional treatment is recommended, a pre-determination can be sent to your insurance company and this will let you know what your cost will be. At this time, our office is not a member of any HMO or PPO dental insurance plan networks, so even a referral from your general dentist does not guarantee that I can receive full payment from your insurance company. If you do not have dental insurance or your insurance only pays part of the fee for treatment, we will review the payment plan options with you.

A few insurance plans, such as Delta Dental, will not pay our office directly because we are not members on their plan. We will file a claim for you and payment will be made directly to you by the insurance company; therefore, you are responsible for payment in full for the treatment.

If you have any questions concerning insurance, feel free to call our office. If any problems with pain or infection should occur before your visit, call and notify our staff of this change. We look forward to meeting you and working together on your periodontal health and treatment needs.

Sincerely,

Kayleigh E. Temple, DDS, MS
John E. Adcock, DDS, MS
Diplomates of the American Board of Periodontology

3805 Brookside Drive Tyler, Texas 75701 (903) 581-2900

Tyler Periodontics

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CONSENT TO EXAMINATION, DIAGNOSIS, AND INITIAL NON-SURGICAL THERAPY

Patient Name: _____ Age: _____ Date: _____

To Dr. Temple and/or Dr. Adcock:

I, the undersigned, have requested that you perform examination, diagnosis, and non-surgical treatment as your judgment indicates. Further, if in the course of contemplated treatment, a different or more extensive treatment, in your judgment, is required, you are fully authorized to proceed therewith.

The undersigned is obligated and bound to hold you and/or your associates harmless from any and all consequences for such examination, diagnosis, and treatment provided that your duties are performed to these standards of care and to the best of your ability. If these standards have been met, you and each of your associates are hereby fully released from any and all claims and demands whatsoever which might arise, grow out of, or be incident to, such diagnosis and/or treatment.

Furthermore, I am aware of the fact and fully understand that no medical or dental procedure is without risks, possible alternative methods of treatment, or the possibility of complications. I also hereby agree that I will not permit any work to be done until such time as reasonable explanations of the risks, possible alternative methods of treatment, and possible complications are made to my satisfaction. I also clearly understand that such explanations may not nor need not be totally or fully comprehensive, depending upon my wishes. Presentation of myself to this office for any treatment shall constitute full and unconditional binding agreement to all the terms of this consent form.

I also agree that a new consent form will be needed for any surgery and/or the administration of anesthesia at any future date. I further acknowledge that no guarantee of assurance has been or will be made as to any possible results that may be obtained.

I certify that I have read and fully understand the above consent form, that any necessary explanations of this form have been made to me, and that all blanks or statements requiring insertion or completion were filled in before I affixed my signature.

_____ _____

Signature of Patient Witness

3805 Brookside Drive Tyler, Texas 75701 (903) 581-2900

Tyler Periodontics

Dr. Kayleigh E. Temple & Dr. John E. Adcock

INSURANCE FORM

I hereby agree to assign all insurance payments to Tyler Periodontics by provider John E. Adcock, DDS, MS or Kayleigh E. Temple, DDS, MS. I am also aware that my insurance may not cover the full professional fee. I hereby agree to pay my percentage which the insurance does not cover at the time of services. I understand that any additional payment by the insurance company will be reimbursed to me.

I hereby agree that if the insurance company partially pays or fails to pay Tyler Periodontics, John E. Adcock, DDS, MS, or Kayleigh E. Temple, DDS, MS within sixty (60) days of the rendered treatment, any outstanding fees will be paid by me at that time.

Date: _____

Signature of Patient: _____

Witness: _____

I hereby authorize payment directly to Tyler Periodontics, John E. Adcock, DDS, MS or Kayleigh E. Temple, DDS, MS of the insurance benefits otherwise payable to me.

_____	_____	_____
Patient Name	Patient Signature	Date

Delta Dental Insurance Plan Holders - I understand that my insurance is not contracted with Tyler Periodontics, PLLC. I hereby understand that I am fully financially responsible for services rendered by John E. Adcock, DDS, MS or Kayleigh E. Temple, DDS, MS. I understand that my insurance may not cover the full professional fees. I hereby agree to pay the full professional fee at the time of service.

_____	_____	_____
Patient Name	Patient Signature	Date

3805 Brookside Drive Tyler, Texas 75701 (903) 581-2900

Tyler Periodontics

Dr. Kayleigh E. Temple & Dr. John E. Adcock

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Printed Name

_____
Signature of Patient

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policy, but acknowledgement could not obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Tyler Periodontics

Dr. Kayleigh E. Temple & Dr. John E. Adcock

RECORDS RELEASE FORM

Date: _____

TO: _____

Dentist

_____

Address

I hereby authorize and request you to release the complete dental records in your possession concerning my treatment while a patient in your office to:

Tyler Periodontics, PLLC - Kayleigh E. Temple, DDS, MS & John E. Adcock DDS, MS
3805 Brookside Drive Tyler, Texas 75701
Office: (903) 581-2900 Fax: (903) 509-0160
info@tylerperio.com

_____ _____ _____

Patient Name Patient Signature Date

_____

Witness

PATIENT INFORMATION & HEALTH HISTORY SHEET

Patient Name: _____
Last Name First Middle Preferred Name

Street Address: _____
City State Zip

Home Phone_____ Cell Phone_____ Patient Birthdate _____ Age _____ Sex: M F

Marital Status (Please check one: _____S _____M _____D _____W SSN: _____

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Person responsible for bill if other than patient: _____

_____
Address City State Zip Phone Number SSN

Do you have dental insurance? Yes No

_____
Company Name Address City State Zip Phone Number

_____
Insured Name Insured SSN Insured DOB Group #

DENTAL HISTORY

Whom may we thank for referring you? _____

Name of general dentist, if different: _____

What dentist(s) have you seen in the last five years? _____

How often have you had your teeth cleaned? Regularly Infrequently Never

Have you experienced any problems with previous dental work? _____

Are you apprehensive regarding dental treatment or dental offices? Yes No

Have you experienced any reactions to local anesthetic? Yes No

What is your chief complaint today? _____

BRIEF MEDICAL HISTORY

List of Current Medications: _____

Medication Allergies: _____

Are you presently under the care of a physician? Yes No _____
Name of Physician

If yes, for what condition? _____

Have you ever had any of the following:

	High Blood Pressure		Rheumatic Fever		Heart Condition
	Diabetes		Bleeding Disorder		Thyroid Problem
	Tuberculosis		Seizures		Hip/Knee Replacement
	Cancer		Heart Murmur		Stomach Ulcers

Do you have reason to believe you have been exposed to the AIDS virus through:

_____ Blood Transfusion _____ High Risk Group _____Other

Have you been tested for HIV? Yes No

Women: Do you suspect that you may be pregnant? Yes No

Signature: _____ Date: _____