Tyler Periodontics & Dental Implants

Patient Name: _____

Patient Date of Birth: _____

Appt Date & Arrival Time: _____

THE FIRST APPOINTMENT

Thank you for scheduling an appointment in our office. Attached you will find a "Patient Information & Health History" form. 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 consultation visit is around $125, and patients are required to pay 100% of the initial visit fee regardless of insurance coverage.** *Occasionally, there is a need to take x-rays, or perform additional treatment which are completed at an additional charge.*

Our Doctors:
Dr. Temple and Dr. Kennedy are both board certified in periodontology and dental implantology by the American Board of Periodontology. Both have an additional 3 years of advanced residency training, specializing in periodontics and dental implants. Our doctors take a collaborative approach to patient care and plan many complex cases together to ensure ideal treatment outcomes. You will likely have the opportunity to work with both doctors while you are a patient in our office.

Initial Visit:
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.

Treatment Discussions:
We are aware that considering all of the options and possibility of care can sometimes be overwhelming, especially when multiple doctors are involved. Our goal is to provide you with all of the information and education needed to help you make well informed treatment decisions. We will use detailed information from your clinical examination as well as photographs, example models, and before-and-after cases to assist your understanding. You will also be given ample time to ask any questions regarding treatment types and options. Our treatment plans are based on your needs as a patient and not according to your insurance coverage.

Financial Policies:
Prior to receiving treatment, we will provide you with a treatment plan, including a detailed review of the dental treatment codes and fees associated. ***Payment in full is due at the time services are rendered.*** We accept cash, check, and most major credit cards. There is a $25 fee for returned checks. Alternative payment arrangements may be made on a case by case basis.
Surgical appointments require full payment 10 business days prior to the scheduled appointment. Failure to pre-pay will result in cancellation of your appointment.

Dental Insurance Policies:
If you have dental insurance, bring your insurance card or information to your appointment. It is important to remember that dental insurance is different than medical insurance. Benefit coverage is often far more limited, and dental insurance companies will never guarantee their level of reimbursement before a service is performed. ***As a professional courtesy to you, we will file your insurance claim for surgical procedures.*** *We will also do our best to verify potential benefits prior to treatment, but this does not guarantee that your insurance will cover a provided service.*
At this time, our office is not a member of any dental insurance plan networks, so even a referral from your general dentist does not guarantee that we can receive full payment from your insurance company. Because we are out of network, many insurances do not communicate with our office regarding insurance claims. As such, full payment for services is due at the time services are rendered. Payments received from your insurance will then be reimbursed back to you in a timely fashion (usually within 2-3 weeks of receipt, unless a past due balance is present).

Appointment Reservations:
Our office is fully committed to providing you with individualized, compassionate, high quality care at each visit. We prepare prior to your visit to ensure each visit exceeds expectations. As such, we ask that you carefully consider your calendar when you make an appointment with our practice.
All surgical appointments require 7 days notice for cancelling or rescheduling.
A $50 late fee will be charged for late cancellation (less than 7 days) of surgery appointments or for late cancellation (less than 48 hours) or failure to show for any other appointment, including hygiene cleaning visits.
Patients who arrive more than 15 minutes late to their appointment may be asked to reschedule as a courtesy to other scheduled patients.

If you have any questions regarding the above information, feel free to call our office. If any problems with pain or infection should occur before your visit, please 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,
Dr. Kayleigh E. Temple, DDS, MS and Dr. Aly Kennedy, DDS, MS
Diplomates of the American Board of Periodontology

Please sign below to acknowledge that you have read and understood our policies.

Patient Acknowledgment: _____ Date: _____

Office Administration Signature: _____ Date: _____

Tyler Periodontics
& Dental Implants

PATIENT INFORMATION

Name: _____ M F Age: _____ Birthdate: _____
Last Name First Name Middle Initial Preferred Name

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

SSN: _____ Driver's License #: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____ Employer: _____ Work Phone: _____

Referring Dentist(s): _____

In case of an emergency, who should be notified? _____ Phone: _____

Responsible Party (if someone other than the patient): _____
Last Name First Name Initial

Birthdate: _____ SSN: _____ ☐ Responsible party is also Policy Holder for Patient ☐ Primary ☐ Secondary

PRIMARY INSURANCE

☐ Self ☐ Spouse

Name of Insured: _____ Relationship to Insured: ☐ Child ☐ Other
Last Name First Name Initial

Birthdate: _____ SSN: _____ Phone: _____

Address (if different from patient): _____

Employer: _____ Work Address: _____

Insurance Company: _____
Name Address City, State, Zip

Phone: _____ Group/Plan#: _____ Subscriber ID#: _____

SECONDARY INSURANCE

☐ Self ☐ Spouse

Name of Insured: _____ Relationship to Insured: ☐ Child ☐ Other
Last Name First Name Initial

Birthdate: _____ SSN: _____ Phone: _____

Address (if different from patient): _____

Employer: _____ Work Address: _____

Insurance Company: _____
Name Address City, State, Zip

Phone: _____ Group/Plan#: _____ Subscriber ID#: _____

MEDICAL HISTORY FORM

Height: Weight:

Are you ALLERGIC (rash, hives, swollen throat, anaphylaxis) to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Local Anesthetics
☐ Metal	☐ Latex	☐ Sulfa	☐ Medical Tape/Adhesive
☐ Food Allergies _____		☐ Others (please list): _____	

Do you have or have you had any of the following? Circle Y or N for each

Congestive Heart Failure	Y N	Sickle Cell Disease	Y N	Osteoporosis / Osteopenia	Y N
Angina	Y N	Blood Thinner Medication	Y N	Artificial Joint (Knee, Hip, Shoulder)	Y N
Rheumatic / Scarlet Fever	Y N	Hemophilia	Y N	Gout	Y N
Heart Attack / MI	Y N	Pregnancy / Nursing	Y N	Thyroid Problems	Y N
Cardiac Stent	Y N	Post-Menopausal	Y N	Diabetes Mellitus - 1 or 2	Y N
Blood Transfusion	Y N	Birth Control Pills	Y N	Overweight / Obesity	Y N
High Blood Pressure	Y N	Nausea / Vomiting / Diarrhea	Y N	AIDS / HIV Infection	Y N
High Cholesterol	Y N	Gastric Ulcers	Y N	Hepatitis - A B C	Y N
Pacemaker	Y N	Acid Reflux	Y N	Rheumatoid Arthritis	Y N
Cardiac Arrhythmia	Y N	Depression	Y N	Lupus	Y N
Obstructive Sleep Apnea (OSA)	Y N	Anxiety	Y N	Crohn's / Ulcerative Colitis / IBS	Y N
Stroke / TIA	Y N	Migraine Headaches	Y N	MS	Y N
Artificial Heart Valve	Y N	Epilepsy / Seizures	Y N	Fibromyalgia	Y N
Congenital Heart Defect	Y N	Parkinsons / Tremors	Y N	Seasonal Allergies	Y N
Chronic Cough	Y N	Dementia / Alzheimers	Y N	Sinus Problems	Y N
Asthma	Y N	Insomnia	Y N	Glaucoma / Cataracts	Y N
Chronic Respiratory Infections	Y N	Restless Leg Syndrome	Y N	Hearing Loss / Deafness	Y N
Emphysema	Y N	Peripheral Neuropathy	Y N	Cancer	Y N
COPD	Y N	Chronic Pain	Y N	Bladder Problems	Y N
Anemia	Y N	ADD / ADHD	Y N	Renal Problems / Dialysis	Y N
Liver Problems	Y N	Osteoarthritis (joint pain)	Y N	Benign Prostate Hypertrophy / ED	Y N
Please list all surgical history:					
Any problems with anesthesia?	Y N				

Primary Care Physician:		Phone:	
Additional Physician(s):			

Social History

☐ Smoking ☐ Former Smoker	# of cigarettes per day: _____	Age started smoking: _____
☐ Vaping	☐ Rarely ☐ Weekly ☐ Daily	Age started vaping: _____
☐ Drink Alcohol	☐ Rarely ☐ Weekly ☐ Daily	_____ drinks per ☐ day ☐ week
☐ Drug Use	Type:	☐ History of Abuse

Please list all medications (prescribed and over the counter):
Preferred Pharmacy:

DENTAL HISTORY FORM

How often do you have your teeth cleaned?	Regularly		Infrequently	Never
How would you rate your level of dental anxiety?	None	Mild	Moderate	Severe
What is your chief concern today?				

To the best of my knowledge, all of the answers and information provided are true and correct. I understand that I must inform my doctors of any changes to my health or medications at each visit. I understand that failing to provide accurate information or intentionally withholding information can be dangerous to my personal health.

Patient Name	Signature	Date
_____	_____	_____

Consent to Examination, Diagnosis, and Initial Non-Surgical Therapy

I, the undersigned, have requested that you perform examination, diagnosis, and non-surgical therapy 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.

I, the undersigned, am obligated and bound to hold you and/or your associates harmless from any and all consequences of 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 diagnoses and/or treatments.

Furthermore, I am aware of the fact and fully understand that no medical or dental procedure is without risks, possible alternative methods of treatment, and/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 on 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 or assurance has been made 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.

Printed Name	Signature	Date
_____	_____	_____

_____

Office Administration Signature

Tyler Periodontics & Dental Implants

KAYLEIGH E. TEMPLE, DDS, MS
Diplomate of the American Board of Periodontology

ALY KENNEDY, DDS, MS
Diplomate of the American Board of Periodontology

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 your 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 _____, 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, provide 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 made 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 or disclose your health information to obtain payment for services we provide 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 health 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 int he notification of (Including identifying or locating) 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 discloser 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 judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgement and our experience with common practice to make reasonable inferences o you best interest in allowing a person to pic up filled 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 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 obtain 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. We will charge you a reasonable cost-based fee for expenses such as copies 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 $0.50 for each page, $30.00 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 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 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 than treatment, payment, healthcare operations, and certain other activities, but not before January 1, 2017. 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.
Electronic Notice: If you receive this Notice on our website or by electronic form (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, 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 alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also 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.

Contact Officer: Kayleigh Eaves Temple, DDS, MS
Telephone: 903-581-2900 Fax: 903-509-0160
Email: info@tylerperio.com Address: 3805 Brookside Drive Tyler, Texas 75701

Tyler Periodontics & Dental Implants

KAYLEIGH E. TEMPLE, DDS, MS
Diplomate of the American Board of Periodontology

ALY KENNEDY, DDS, MS
Diplomate of the American Board of Periodontology

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 & Dental Implants

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment, and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or healthcare operations.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient | Legal Relationship to Patient

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of individuals you authorize our offices to discuss care with.

I authorize Tyler Periodontics to share my health information with:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

CONSENT TO EMAIL OR TEXT FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATION

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke that consent at any time.

I authorize Tyler Periodontics to contact me by text message for appointment reminders and general health information at the following cell phone number: _____ Initials: _____

I authorize Tyler Periodontics to contact me by email for appointment reminders and general health information at the following email address: _____ Initials: _____

_____ I decline to receive communications via text messaging. _____ I decline to receive communications via email.

Revocation: Use this area to documentation revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text messaging.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient Signature: _____ Date Requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible.
This form does not constitute legal advice and covers only federal, not state, law.

Tyler Periodontics & Dental Implants

KAYLEIGH E. TEMPLE, DDS, MS
Diplomate of the American Board of Periodontology

ALY KENNEDY, DDS, MS
Diplomate of the American Board of Periodontology

AUTHORIZATION TO DISCLOSE / OBTAIN PROTECTED HEALTH INFORMATION (PHI) - RECORDS RELEASE FORM

I hereby authorize and request you to release the complete medical records, including blood work, medication list, and relevant healthcare information in your possession concerning my treatment while a patient in your office to:

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

_____ _____ _____
Patient Name Patient Signature Date

_____
Office Administration Signature

For Office Use Only

Patient Name: _____ Date of Birth: _____

❑ Obtain information FROM ❑ Release information TO

_____ _____
Name of Entity Phone Number

INFORMATION TO BE RELEASED / ACCESSED:

- ❑ Operative Report
- ❑ Lab / Pathology Report
- ❑ Emergency Room / Urgent Care Report
- ❑ Clinic Notes
- ❑ Radiographs (x-rays, CBCT, etc.)
- ❑ Periodontal treatment record(s) and charting
- ❑ Other: _____

Tyler Periodontics & Dental Implants

KAYLEIGH E. TEMPLE, DDS, MS
Diplomate of the American Board of Periodontology

ALY KENNEDY, DDS, MS
Diplomate of the American Board of Periodontology

PHOTO AND RADIOGRAPH RELEASE FORM

I, _____, hereby allow the office of Tyler Periodontics & Dental Implants, PLLC and Dr. Kayleigh E. Temple, DDS, MS and Dr. Aly Kennedy, DDS, MS to use the photographs and/or radiographs of my teeth taken while being seen in their office for use in the following manner(s):

_____ Educational programs and continuing education

_____ Research purposes

_____ Company website

_____ Social Media

I understand that my identity will remain anonymous. I understand that there will be no identifying features shown on any photographs and/or radiographs used.

_____	_____	_____
Signature of Patient or Legal Representative	Printed Name of Patient	Date

Tyler Periodontics & Dental Implants

KAYLEIGH E. TEMPLE, DDS, MS
Diplomate of the American Board of Periodontology

ALY KENNEDY, DDS, MS
Diplomate of the American Board of Periodontology

INSURANCE ASSIGNMENT OF BENEFITS FORM

I hereby authorize Tyler Periodontics to submit claims for payment of services on my behalf and in my name. I hereby authorize payment directly to Tyler Periodontics, Kayleigh E. Temple, DDS, MS, Aly Kennedy, DDS, MS or other associates of the insurance benefits otherwise payable to me.

Tyler Periodontics is not contracted with any insurance company; as such, I understand that insurance may not cover the full professional fee. I understand that I am financially responsible for the entirety of professional fees. I hereby agree to pay the full professional fee at the time of service. I hereby agree that if the insurance company partially pays or fails to pay Tyler Periodontics & Dental Implants or Kayleigh E. Temple, DDS, MS or Aly Kennedy, DDS, MS within sixty (60) days of the rendered treatment, any outstanding fees will be paid by me at that time.

Please read the following policies regarding dental insurance:

- As a professional courtesy to our patients, we will file insurance claims for surgical procedures. We will also do our best to verify potential benefits prior to treatment, but this does not guarantee that insurance will cover a provided service.
- Our office does not accept responsibility - under any circumstance - for the outcome of an insurance claim. Our office will not enter into a dispute with insurance over a claim, although we will work with an insurance company to provide necessary information for claim payment. It is the responsibility of the patient to manage any disputes over payment directly with the insurance company.
- Because we are out of network, many insurances do not communicate directly with our office regarding claims. As such, full payment for services is due at the time services are rendered.
- Most insurance companies process claims within 30 to 60 days. Payments received from your insurance will then be reimbursed back to you in a timely fashion (usually within 2-3 weeks of receipt, unless a past due balance is present).

Please sign below indicating that you have read and understand the above insurance policies.

_____	_____	_____
Patient Name	Patient Signature	Date

Office Administration Signature: _____