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 $140, 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

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 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.

PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:

Privacy Official Name: Kayleigh Temple, DDS, MA, MS | Aly Kennedy, DDS, MS

Telephone: (903) 581 - 2900 Fax: (903) 509 - 0160

Address: 3805 Brookside Drive Tyler, TX 75701

Email: admin@tylerperio.com

This material is educational only, does not constitute legal advice, and covers only federal, not state, law. Changes in applicable laws or regulations may require revision. Dentists should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations.

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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)

_____

_____

_____

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Reproduction and use of this form by dentists & their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association. This form is educational only, does not constitute legal advice, and covers only federal, not state law (August 14, 2002).

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: _____