Kurt E. Delius, D.D.S, M.S.

Central Texas Perio and Implants

10123 Lake Creek Pkwy, Bldg. 1
Austin, Tx 78729
(512)335-3600

Authorization to Disclose Health Information

Name_____ Date_____

Protected Health Information (PHI) may include documents regarding dental or medical treatment including, but not limited to, diagnosis, procedures, treatment plans, appointments, test results, accounting and billing information, insurance information and claim status, payment arrangements and third party financing.

(Check One) I do __ do not__ GIVE PERMISSION to **Central Texas Perio and Implants** to leave information on my answering machine and / or with my family members in regard to treatment plans, procedures, diagnosis, referrals, test results, billing and payment information, insurance information and appointment date and time. HIPAA guidelines do allow for basic information regarding appointment date and times to be left on answering machines and / or with family members.

_____ _____

Signature of Patient or Guardian Relationship of Guardian

KURT E. DELIUS, .D.D.S., M.S.
Periodontics and Dental Implants

10123 Lake Creek Parkway Bldg. 1
Austin, Texas 78729
(512) 335-3600

OUR FINANCIAL & INSURANCE POLICY

Thank you for selecting our office for your periodontal care. We are committed to providing the highest quality care for our patients, using the latest techniques. We want all aspects of your treatment to go smoothly. We feel it is important for you to understand that payment of your bill is part of the treatment process and that you should know our policy and your responsibility regarding it. With this in mind, we require that you read and sign our Financial Policy statement prior to any treatment.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, AND DISCOVER.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, we will assist you in filing claims with your insurance company so you may be reimbursed. We may accept assignment of insurance benefits after your second visit. In the event that we do accept assignment of benefits, we require that your treatment be pre-approved by your insurance company. However, we do require 75% of the bill to be paid at the time of service. The balance remains your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 45 days, the balance will be due. We need your insurance information and an original claim form to be able to help you file your claim. Please be aware that our services are not covered under the Medicare Program.

With regard to insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to one where we are not participating providers, refer to above paragraph.

Usual and Customary Rates

Our fees are charged according to what is usual and customary for our area. Our practice provides the highest standard of treatment for our patients. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or Discover; or unless payment by cash or check at the time of service has been verified.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at a rate of a normal office visit. When you schedule an appointment with our office, we consider it confirmed and do not give it to any other patient. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please do not hesitate to discuss any questions or concerns with us.

I have read the Financial Policy for Kurt E. Delius, D.D.S., M.S. I understand and agree to this Financial Policy.

X_____ Date_____

Signature of Patient or Responsible Party

_____

Printed Name of Signature

Central Texas Perio and Implants

Kurt E. Delius D.D.S., M.S.

Todays Date:_____ Referred By:_____

Patient Name:_____ Date of Birth: _____

Medical History: Please circle yes or no for each question.

Are you currently being treated by a physician? **Y N** Physician's Name/Number: _____

Are you taking **ANY** prescription or over the counter medications?

Y N Antibiotics
Y N Medications for High Blood Pressure
Y N Medications for heart conditions
Y N Anticoagulant/Blood thinners
Y N Aspirin Daily
Y N Cortisone/Steroids
Y N Mood Elevators/Antidepressants
Y N Osteoporosis Medication
Y N Dietary Supplements like Fish Oil, Vit. E
Y N Non-prescribed or illegal drugs

List any other medications_____

_____

Have you ever had an adverse reaction to any of the following:

Y N Aspirin, Advil
Y N Dental Anesthetics
Y N General Anesthesia
Y N Codeine/Narcotics
Y N Penicillin
Y N Tetracycline
Y N Sulfa Drugs
Y N Erythromycin
Y N Latex

List any other adverse reactions:_____

For Women:

Y N Are you Pregnant?
Y N Are you Nursing?
Y N Are you Taking Birth Control?
Y N Taking Hormone Medication?
Y N Through Menopause?

Do you have or have you ever had any of the following?

Y N Heart Disease
Y N High/Low Blood Pressure
Y N Artificial Heart Valves
Y N Heart Murmur
Y N Pace Maker or Defibrillator
Y N Mitral Valve Prolapse
Y N Rheumatic Fever
Y N Stroke
Y N Seasonal Allergies
Y N Asthma
Y N Emphysema, Tuberculosis
Y N Hepatitis or Liver Disease
Y N Kidney Disease, Bladder Disease
Y N Stomach/Intestinal Problems
Y N Thyroid Problems
Y N Diabetes
Y N Prolonged Bleeding
Y N Artificial Joints
Y N Cancer
Y N Chemotherapy
Y N Radiation
Y N Sexually Transmitted Disease
Y N HIV+/AIDS
Y N Epilepsy, Seizures

Do you Smoke? Y / N How much? _____

Any Surgery in the last 5 years? _____

Family History of: Heart Disease **Y N** High Blood Pressure **Y N** Diabetes **Y N** Other _____

Dental History:

Y N Do your gums bleed while brushing/flossing
Y N Have you ever had an abscess
Y N Had braces/orthodontics
Y N Had Instructions on brushing/flossing
Y N Had ulcers/blisters in your mouth
Y N Do you clench/grind you teeth
Y N Do you have a fear of dental treatment
Y N Sensitive to Hot or Cold Liquids/Food
Y N Loose or shifting teeth
Y N Food trapping between teeth
Y N Frequent bad breath
Y N Frequent Headaches
Y N Sore/Popping of jaw joint
Y N Have you ever been treated for Periodontal Disease

Consent for Examination / Treatment

I hereby grant authority to the Doctor in charge to perform procedures that are deemed necessary or advisable in my diagnosis and treatment

Patient Signature_____ **Date:**_____

CENTRAL TEXAS PERIO AND IMPLANTS
KURT E. DELIUS D.D.S., M.S.
(Please Print)

Today's date:			Referred by:		
PATIENT INFORMATION					
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status
Preferred Name:		Date of Birth:			Sex: M / F
Street address:		Social Security no.:			Cell Phone: ( )
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:		Work Phone: ( )		
Other family members seen here:					

RESPONSIBLE PARTY/INSURANCE INFORMATION					
Responsible party:	Birth date: / /	Address (if different):	Home Phone: ( )		
Is this person a patient here?	❑Yes ❑ No				
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance?	❑ Yes ❑ No				
Please indicate primary insurance					
Subscriber's name:	SS# or Member ID.:	Birth date: / /	Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group #:	Policy #:	
SS# or Member ID:	Date of Birth:				
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
Name :	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Central Texas Perio and Implants or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*