Kenneth R. Russell, D.D. S. PA

Kenneth R. Russell, D.D.S. Casey T. Reynolds, D.D.S.

1480 Rymco Drive, Suite B; Winston-Salem, N.C. 27103

Patient Registration

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient's Name _____ _____ _____ Date _____

Last Middle First Preferred

Patient's Birthdate ____/____/____ Social Security Number _____ - _____ - _____

SINGLE ___ MARRIED ___SEPARATED ___DIVORCED ___WIDOWED ___

Home Address_____

Street City State Zip

Home Telephone _____ Work Telephone _____ Cell Phone _____

Preferred contact method(s) (please circle): Home / Cell / Work/Email E-mail Address: _____

Patient's Occupation _____ Patient's Employer_____

Business Address _____

Who may we thank for recommending you to our practice? _____

Spouse or Parent's Name (if patient is a minor) _____ _____

Last Middle First Preferred

Spouse or Parent's Birthdate: _____/_____/_____ Spouse or Parents Contact Number(s)_ _____

Spouse or Parent's Occupation _____ Employer _____

In case of an Emergency, please contact _____

Home Phone _____ Cell Phone _____ Work Phone _____

Who is responsible for this account? _____

DENTAL INSURANCE

PRIMARY COVERAGE

Employee Name _____
Employee Date of Birth _____
Employer Insurance Company _____
Policy/ Member ID No. _____
Group No. _____
Ins. Company Phone No. _____

SECONDARY COVERAGE

Employee Name _____
Employee Date of Birth _____
Employer Insurance Company_____
Policy/Member ID No._____
Group. No. _____
Ins. Company Phone No. _____

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Office Guidelines

Dental Insurance: Please note the following:

- Dental insurance is a contract between your Employer and the Insurance Company to assist you in meeting dental financial obligations. Your employer chooses the plan and the benefit level; it is not based upon treatment needed.
- Dental insurance is an aid and is NOT designed to cover all treatment costs.
- Most plans are written to cover only minimal care; please be aware that some, or perhaps all, of the services provided by our office may not be covered by your dental insurance company.
- Our office expects payment at time of service., If insurance is involved; our office will take every effort to provide an ESTIMATED amount that is due at time of service. This ESTIMATE is based on the information we have been provided by your insurance carrier. Please be aware that any misinformation provided to us by your insurance is not our liability.

Financial Arrangements: Financial arrangements will be made prior to treatment. We accept cash, check, Visa, American Express, MasterCard, and Discover for your convenience. In addition, we offer payment plan options through Care Credit upon approval. Past Due balances of 30 days or more will be charged an additional 1.5% monthly (18% APR).

Broken Appointment Policy: Your appointment has been reserved specifically for you. If you are unable to keep the appointed time; we ask for 48-hour notice so that we may use this appointed time for another patient. Consistent broken appointments, late arrivals (over 15 minutes of appointed time), and appointments cancelled with less than 48 hours' notice may necessitate a broken appointment fee ($47 per hour for duration of appointment length) or our office being unable to reschedule you or continue with your treatment. Note: Late arrivals of over 15 minutes will be rescheduled.

Notice of Privacy Practices: A copy of our Privacy Practices is included in your new patient forms. The practice reserves the right to change the terms of its Notice of Privacy Practices and to make provisions effective for all protected health information that it maintains. By signing below; you acknowledge that you obtained this practice's current Notice of Privacy Practices and may request a copy at any time.

Informed Consent for Treatment: As a patient of this practice, I understand that, during the course of examination, it may be determined that I require treatment on my teeth, gums, soft tissues, or other areas of the head and neck. I understand that is my right to be informed about these treatments and to ask my questions related to them to be better informed about my treatment decisions. I understand that some treatments cannot be completed in this office, and that I may require a referral to a specialist or other medical professional.

Should treatment be recommended, I understand that I may receive local anesthetic and/or other medications to make my treatment more manageable. In rare instances, patients may have a severe reaction to the anesthetic, which ay require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing or aspirating foreign projects during treatment. I understand it is my responsibility to report a history of allergic or adverse reactions to local anesthesia, I may need a designated driver to take me home. Very rarely, temporary or permanent injury can result from an injection.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. Should these changes arise, I will be informed by my provider.

The information I have provided is complete and accurate to the best of my knowledge. I consent to whatever procedures are deemed necessary to diagnose my oral condition. I agree to be responsible for payment of all services rendered. I authorize a credit check should I ask for a credit. I acknowledge that I have read and understand the Office Guidelines.

Signature of Patient, or Parent/Guardian, if patient is under 18 yrs. old: _____

Date: _____

Witness (Signed by Office Personnel): _____ 1/2023