WELCOME. We are pleased that you chose us for your periodontal and implant health care needs. From prevention to advanced treatment, our team works together to offer you and your family the high level of care you are looking for. Our friendly staff, relaxed environment, and caring attitude will put you at ease when you come into our office. Our entire team is dedicated to providing you with a pleasant visit and results that you are proud to show off.

Feel free to browse our website www.krperio.com and learn about our doctor and services.

FIRST VISIT. Your initial appointment usually will consist of a comprehensive oral examination by our Board Certified Periodontist, Dr. Katherine Rodriguez, including all necessary x-rays and intraoral photos, study models (if necessary), oral cancer screening, and gum health evaluation. Following this exam, Dr. Rodriguez will review your treatment options. Usually, treatment can be done the same day as the consultation. However, a complex treatment might require planning for another day.

Your appointment, will take approximately 1 hour.

Please assist us by providing the following information:

- Any x-rays taken by a previous dentist. You may request that they forward them to our office via email to info@krperio.com. If there is not enough time, please pick them up and bring them to our office. If additional x-rays are necessary, they can be taken at our facility.
- A list of medications you are presently taking.
- If you have dental insurance, and would like to use your benefits towards your consultation, please provide us with your dental insurance information. We make every effort to work hand-in-hand with you to maximize your insurance reimbursement for covered procedures.

IMPORTANT: All patients under the age of 18 must be accompanied by a parent or guardian.

FORMS. Our NEW PATIENT FORMS are enclosed for you to fill out.

Please bring these, along with your insurance card, to your first appointment. This will ensure that we spend all our time with your rather than with paperwork. You may also email them to info@krperio.com once completed.

RESCHEDULING. We ask that you make every effort to keep your appointments. If you are unable to make the appointment you have scheduled with us, as a courtesy to our other patients, we kindly request two business days' notice when rescheduling appointments.

PARKING. Our office is conveniently located on the second floor of the Olympic Building located at 951 NE 167th Street. There is ample complimentary parking available for our patients.

Thank you for choosing our practice. We look forward to putting a smile on your face!

NAME: LAST________________________ FIRST______________________ MI______________________________________

STATUS: **O** MALE **O** FEMALE / **O** MARRIED **O** SINGLE **O** CHILD **O** OTHER

PERSONAL: ________________________ ________________________ ___________________________

BIRTHDATE SOCIAL SECURITY # DRIVER'S LICENCE #

ADDRESS: ____

CITY: ____________________________STATE:__________ZIP CODE:______

EMAIL____

PHONE: HOME_________________________ WORK______________________ EXT _______ TIME TO CALL_______________

FAX___________________________ MOBILE__________________________ OTHER_________________________________

PRIVACY REQUESTS: O NO PHONE CALLS **O** DISCLOSURE RESTRICTIONS*(CHECK ONLY IF YOU DO NOT WANT OFFICE TO LEAVE MESSAGE IN ANSWERING MACHINE OR WITH PERSON)*

MEDICAL ALERTS (PLEASE CIRCLE):

PREMEDICTION NEEDED	ALLERGIES____________________	ANEMIA	ARTHRITIS
ARTIFICIAL JOINTS	ASTHMA	BLOOD DISEASE	BLOOD THINNER
CANCER	DIABETES	DIZZINESS	EPILEPSY
EXCESSIVE BLEEDING	FAINTING	GLAUCOMA	HEAD INJURIES
HEART DISEASE	HEART MURMUR	HEPATITIS_____	HERPES
HIGH BLOOD PRESSURE	HIV	JAUNDICE	KIDNEY DISEASE
LIVER DISEASE	MENTAL DISORDER	NERVOUS DISORDER	PACEMAKER
PREGNANCY	RADIATION THERAPY	RESPIRATORY PROBLEMS	RHEUMATIC FEVER
RHEUMATISM	SINUS PROBLEM	STOMACH PROBLEM	STROKE

IS THERE ANYONE IN YOU FAMILY WHO HAS SUFFERED WITH GUM DISEASE AND TOOTH LOSS? ______________________________________

Please list any medications you are currently taking:

Primary Dental Insurance:

Subscriber:___________________________________ **Carrier:**______________________________

Subscriber ID: _________________________________ **Group #** _____________________________

Relationship to subscriber: o self o spouse o child o other

OUR FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy, which require you're to read and sign prior to any treatment. All patients must complete Medical History, Dental History, Financial Policy, and Privacy All forms before seeing the doctor.

REGARDING INSURANCE

At KR Perio we make every effort to provide you with the finest care and the most convenient financial options. To accomplish this we work hand-in-hand with you to maximize your insurance reimbursement for covered procedures. If you have any problems or questions, please ask our staff. They are well informed and up-to-date.

SCHEDULED AND MISSED APPOINTMENTS

Our office has a 72 hour cancellation/rescheduling policy. If you miss your appointment, cancel or change your appointment with less than 72 hours, you will be charged $45. This policy is in place out of respect for our patients and our doctors. Cancellations with less than 72 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot. Thank you for your understanding and cooperation.

Signature_________________________

In an effort to help you attain and maintain optimal overall health, it is appropriate for us to establish a line of communication with the physician and specialists involved in taking care of you. Please provide us with the following information:

Primary Care Physician: _________________________ **Office Phone Number:** ____________________

Cardiologist: __________________________________ **Office Phone Number:** ____________________

Endocrinologist: _______________________________ **Office Phone Number:** ____________________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _________________________________

RELEASES AND SIGNATURES REQUIRED ON FILE

It is required to keep your signature on file, authorizing us to file claims on your behalf to insurance companies.

I hereby authorize Dr. Katherine Rodriguez to release medical and any other information necessary to process my insurance claims.

____

Signature

I authorize payment of dental benefits to Dr. Katherine Rodriguez for services rendered.

____

Signature

I understand that I will be responsible for any fees incurred by Dr. Katherine Rodriguez to collect fees due by me, including collection agency fees, attorney fees, and court cost.

____

Signature

I authorize KR PERIO to send progress reports to my physician and/or specialists to establish and maintain a line of communication.

____

Signature

Patient Acknowledgment of Receipt of the Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. I hereby consent to the use and disclosure of my health information for the purposes and the activities under the federal privacy law. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the office.

_______________________________ ______________

Patient's Name (Please print) Date

____

Signature (if minor Parent or Guardian)

____

Patient's Legal Representative (if applicable)

____

Signature of Legal Representative

FOR DENTAL OFFICE USE ONLY

We attempted to obtain write ACKNOWLEDGEMENT of receipt of our Notice of Privacy Practices, but ACKNOWLEDGEMENT could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the ACKNOWDEGMENT.
An emergency situation prevented us from obtaining ACKNOWLEDGMENT.

Other (please specify) ____