Thank you for choosing Kirkwood Dental Associates, P.A. ~ KDA as your dental provider. We are committed to the latest in technical advances delivered with comfort and care. Below is some important information which we would like to share. All patients must complete and sign this form, prior to receiving services.

Patient Name (PLEASE PRINT): _____

How do you want to be addressed when summoned from the reception area (CHOOSE ONE): ○ First Name Only ○ Proper Surname ○ Other: _____

CANCELLED / MISSED APPOINTMENT POLICY:
When you schedule a dental appointment, Kirkwood Dental Associates, P.A. reserves time in the schedule that is no longer available to other patients. As the time is reserved especially for you, if you are unable to keep your commitment please give us 48 hours notice so that other patients will have prompt access to dental care. KDA reserves the right to charge a $50 broken appointment fee for appointments that are missed and/or cancelled with less than two (2) business days' notice. In the event that multiple appointments are missed and/or cancelled with less than two (2) business days' notice, the patient may be placed on a same day only list. At all times, Kirkwood Dental Associates, P.A. reserves the right to dismiss the patient(s). Arriving more than 10 minutes after your scheduled appointment time may result in the appointment being rescheduled.

HIPAA Consent:

I have received a copy of KDA Notice of Privacy Practices from the practices website when I completed my initial paperwork. With my consent, KDA may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operation (TPO). I also authorize KDA to call my home, cell, or designated location, send email and/or text messages, and leave a message on voicemail, or in person, in reference to any items that assist KDA in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results, among others. With this consent, KDA may mail to my home, cell, or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

Please list the persons with whom we may discuss your information, if needed.

Name: _____Phone #: _____Relationship to the patient: _____

Name: _____Phone #: _____Relationship to the patient: _____

REMAIN IN EFFECT (CHOOSE ONE): ○ Until _____ _____ ***OR*** ○ Indefinitely _____
CHOOSE DATE INITIALS REQUIRED INITIALS REQUIRED

COMMUNICATIONS:

As a service to our patients, we provide courtesy appointments and re-care reminder messages, and other important messages, such as office closures, by using text messages. We also may send text messages notifying you of promotions our practice may offer from time to time. By providing your cellphone number, you consent to receiving text message reminders and notifications at this number. You may opt out of receiving text messages by texting STOP in reply to the message at any time.

Mobile Phone #: _____ Phone Calls **ONLY**, no Text Option _____
INITIALS REQUIRED

We may also provide these messages by e-mail. By providing your e-mail address, you consent to receiving e-mails.

E-mail Address: _____

How would you like to receive your bill, if one pertains to you or your family? (please circle one) Email OR Mail

I HAVE READ ALL OF THE POLICIES ABOVE AND AGREE TO ABIDE BY THE TERMS AND CONDITIONS AS STATED IN EACH.

_____ _____
Signature of Patient (Parent/Guardian if Minor) / Responsible Party Date

_____ _____
Signature of Kirkwood Dental Associates, P.A. Employee Date