PATIENT INFORMATION

Patient Name: ______________________ ______________________ ____ ______________
Last First MI Preferred Name

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth: __________

Social Security #: ________________

Drivers License #: __________

Address: ______________________________ ______________________________
Address 1 Address 2

____ ______ ______-____
City State Zip Code

Phone: __________ __________ __________ _____ **Best time to call:** ______________
Home Mobile Work Ext

Email Address:

____

Occupation/Employer: ________________

SPOUSE/PARENT/GUARDIAN INFORMATION

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________________ ______________________ ____ ______________
Last First MI Preferred Name

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth: __________

Social Security #: ________________

Address: ______________________________ ______________________________
Address 1 Address 2

____ ______ ______-____
City State Zip Code

Phone: __________ __________ __________ _____ **Best time to call:** ______________
Home Mobile Work Ext

Occupation/Employer ________________

Please select one of the following:

◯ I am not filing insurance.

◯ I have insurance I would like to file. (See reverse for insurance information.)

PRIMARY INSURANCE INFORMATION

Name of Insured: ______________________ ______________________ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ ____-____
City State Zip Code

Insured's Employer Name: ______________________

Insurance ID #: ______________________

Group #: ______________________

Insurance Holders Date of Birth: ____________

SECONDARY INSURANCE INFORMATION

Name of Insured: ______________________ ______________________ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ ____-____
City State Zip Code

Insured's Employer Name: ______________________

Insurance ID #: ______________________

Group #: ______________________

Insurance Holder's Date of Birth: ____________

Park City Dental will file your insurance claims on your behalf as a courtesy to you. An isurance card IS NOT a guarantee of benefits. All fees are the patient's responsibility. Insurance in general only covers a portion of the cost of dental procedures. Patients will receive a statement for any balances due that may result after insurance settlements. Insurance benfits are the responsibility of the patient to determine specific coverage amounts. Please consult with your insurance provider for specifics concerning payments, allowances and deductibles.

Signature ______________________________________ Date ____________

Are your teeth sensitive with:

- [ ] Heat?
- [ ] Cold?
- [ ] Sweets?
- [ ] Biting Pressure?

Function of your teeth:

- [ ] Does food catch between your teeth?
- [ ] Have you noticed your gums are swollen around any teeth?
- [ ] Do your gums bleed when brushing?
- [ ] Do you have an unpleasant odor or taste in your mouth?

Problems of the Jaw:

- [ ] Clicking of the jaw?
- [ ] Difficulty opening or closing?
- [ ] Have you ever been diagnosed with sleep apnea?
- [ ] Are you sleeping well at night?
- [ ] Do you ever avoid brusing any area of your mouth?
- [ ] Pain in your jaw joint or ears?
- [ ] Difficulty chewing?
- [ ] Are you currently using a sleep appliance?
- [ ] Do you snore?
- [ ] Have you ever had a reaction to local anesthetic?

Appearance of your teeth:

- [ ] Are you dissatisfied with your teeth and their appearance?
- [ ] Are you concerned about the finances required to return your teeth to excellent dental health?
- [ ] Do you get frustrated because you always have something to be treated or repaired when you visit the dentist?
- [ ] Do you smoke?
- [ ] Have you ever had any teeth removed other than baby teeth or wisdom teeth?
- [ ] Do you feel you will eventually wear artificial dentures?

To the best of your knowledge, are you or have you ever been afflicted with:

- [ ] Heart Ailment
- [ ] Diabetes
- [ ] Rheumatic Fever
- [ ] Epilepsy
- [ ] High Blood Pressure
- [ ] Respiratory Disease
- [ ] Hepatitis
- [ ] HIV Positive
- [ ] Prolonged Bleeding
- [ ] Healing Complications
- [ ] Allergies to Any Drugs
- [ ] Are you pregnant?

Are you currently under a physicians care? If yes, reason:

____

____

Do you have any dental fears? ____________________

What is your present dental problem? ____________________

Have you ever had surgery? If so, please specify: ____________________

How long has it been since your last comprehensive exam? Why did you leave your last dentist?

____

____

How did you hear about our office? Who referred you?

____

____

____

Response Date: __________

Patient Name: ______________________ ______________________ ____ ______________________

Last First MI Preferred Name

Date of Last Dental Visit? Treatment you had completed?

____

____

Current Medical Conditions (check all that apply)

☐ ADHD	☐ Anemia	☐ Anxiety	☐ Arthritis	☐ Asthma	☐ Autism
☐ Blood Disease	☐ Cancer	☐ Diabetes	☐ Dizziness / Fainting	☐ Epilepsy	☐ Fibromyalgia
☐ Glaucoma	☐ Head Injuries	☐ Heart Disease	☐ Hepatitis	☐ High Blood Pressure	☐ HIV/AIDS
☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders	☐ Nervous Disorders	☐ Pacemaker	☐ Pregnancy
☐ Seasonal Allergies	☐ Sinus Problems	☐ Sleep Apnea	☐ STD	☐ Stroke	☐ Ulcers

Please list any medications you are currently taking, or provide a copy of a list.

____

____

Have you had a panoramic x-ray in the last 5 years? ◯ Yes ◯ No

Are you taking any kind of blood thinning medications? ◯ Yes ◯ No

Have you ever taken medication for osteoporosis or cancer treatment? ◯ Yes ◯ No

Do you currently use tobacco? ◯ Yes ◯ No

Are you currently pregnant? If so, when are you due? ______________

Do you have any allergies? (i.e. latex, penicillian, or food allergies) Please list:

____

____

Have you been hospitalized in the last 2 years? If so, please explain:

____

____

Do you have any artificial heart valves or joint replacements? If so, please specify:

____

____

Pleast List: Preferred Pharmacy Name and Phone Number + Emergency Contact Name and Phone Number:

____

____

Signature of patient, parent, or guardian (responsible party):

Signature ____ Date __________

Response Date: __________

Patient Name: ______________________ ______________________ ___ ______________

Last First MI Preferred Name

Consent for Treatment

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in a cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of 3 months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice. I agree to pay he charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment

☐ **I have read the above conditions of treatment and payment and agree to their content**

Financial Policy

All fees are the patients responsibility to pay. The policy of Park City Dental is payment for treatment is due when services are rendered. If you need further clarification of policy and financial options please ask for our financial options brochure and to speak to patient finance.

I intend to pay for my dental treatment/co-insurance today in the following way:
Check as many as apply.

☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit ☐ HSA/FSA

Park City Dental will file your insurance claims on your behalf as a courtesy to you. An Insurance card is not a guarantee of benefits. All fees are the patients responsibility. Insurance in general only covers a portion of the cost of dental procedures. Patients will receive a statement for any balances due that may result after insurance settlements. Insurance benefits are the responsibilities of the patient to determine specific coverage amounts. Please consult with your insurance provider for specifics concerning payments, allowances and deductibles.

Signature ____ Date __________

HIPAA Information and Consent Form

The Health Insurance Portability Act (HIPAA) provides safeguards to protect your privacy. Many of the safeguards have been our policy and practice for many years. Please read the following information and provide your consent.

I hereby give my consent for Park City Dental to use and disclose protected health information (PHI) about me to carry out treatment, payment and administrative matters as required for my care.

I understand and agree that this specifically includes the sharing of information including PHI with other healthcare providers, laboratories, insurance payers and vendors as is necessary and appropriate for my care.

I also agree to the normal procedures utilized by Park City Dental for the handling of patient information and records, PHI and other documents.

It is the policy of Park City Dental to remind patients of their appointments via telephone, email, postcards, letters, or by any other means that are convenient for Park City Dental and or as requested. With this consent, Park City Dental may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out dental care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

By signing this form, I am consenting to allow Park City Dental to use and disclose my PHI to carry out dental care operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Park City Dental reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Park City Dental, Privacy Officer,1615 61st St. N., Suite 300, Park City, KS 67219.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Park City Dental may decline to provide treatment to me.

Signature ______________________________ Date __________

Response Date: __________