

Welcome

Thank you for choosing to visit our dental office. It is our pleasure to meet you! In order to serve you best, please take a moment to provide us with some important information. Your responses are greatly appreciated.

Today's Date _____

Name _____ Preferred name _____
Last First MI Mr Mrs Ms Dr

Birthdate _____ Social Security Number _____ Single Married Divorced Widowed

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail address _____ I prefer to be contacted by: _____

Employer _____ Occupation _____

Who may we thank for referring you? _____

Spouse's name _____

Emergency Contact: neighbor or relative not living with you _____

Relation _____ Phone _____

Insurance information

Do you have dental insurance? _____ Insurance Company name _____

Phone _____ Group number _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ Insured's Social Security Number _____

Insured's Birthdate _____ Insured's Employer _____

Address _____ City _____ State _____ Zip _____

Do you have secondary dental insurance? _____ Insurance Company name _____

Phone _____ Group number _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ Insured's Social Security Number _____

Insured's Birthdate _____ Insured's Employer _____

Address _____ City _____ State _____ Zip _____

Medical History

Physician's name _____ Phone number _____

Date of last visit to physician _____ Reason for visit _____

Please list prescription medications, over-the-counter medications, and supplements you are currently taking:

If taking other medications, please list: _____

Have you ever taken Fosamax, bisphosphonates, or other medication for osteoporosis? _____

Have you ever taken Phen-Phen, Redux, or Pondimin? _____

Have you ever been prescribed an antibiotic to take before dental visits? _____

Women: Are you... pregnant? _____ nursing? _____ taking birth control pills? _____

Are you aware of being allergic to any of the following? (Please check)

<input type="checkbox"/> Acrylic	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Sedatives
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Jewelry / Metals	<input type="checkbox"/> Sulfa drugs
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Latex	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Codeine	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other
<input type="checkbox"/> Dental local anesthetics		

Please check if you have or have been treated for any of the following:

<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> Fainting / dizziness	
<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Mitral valve prolapse
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Angina	<input type="checkbox"/> Hay fever / allergies	<input type="checkbox"/> Radiation treatments
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart attack / heart failure	<input type="checkbox"/> Renal dialysis
<input type="checkbox"/> Artificial joint	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart pacemaker	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Blood disease	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Shingles
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Herpes	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Chest pains	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Sinus trouble
<input type="checkbox"/> Cold sores / fever blisters	<input type="checkbox"/> Hives or rash	<input type="checkbox"/> Stomach / intestinal disease
<input type="checkbox"/> Congenital heart disorders	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cortisone medication	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Tumors or growths
<input type="checkbox"/> Drug addiction	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Lupus	<input type="checkbox"/> Yellow jaundice
<input type="checkbox"/> Other serious illness not listed: _____		

I affirm that the medical information provided here is correct to the best of my knowledge:

Signature _____ Date _____

Dental Questionnaire

Accurate answers to the following questions will allow us to treat you on an individual basis, providing the care appropriate to your particular needs.

Are you having discomfort at this time?	Yes	No
Have you had problems with any previous dental work?	Yes	No
Are you apprehensive about having dental work done?	Yes	No
Have you been treated for gum or periodontal disease?	Yes	No
Have you had orthodontic treatment (braces)?	Yes	No
Have you had wisdom teeth removed?	Yes	No
Do you smoke?	Yes	No
Do you use smokeless tobacco?	Yes	No
Do you use an electric toothbrush?	Yes	No
Do you use dental floss?	Yes	No
Do you use mouthwash?	Yes	No

Previous dentist _____ Date of last dental visit _____

Why did you leave your previous dentist? _____

Do you have any of the following?

Bleeding, sore gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste/bad breath	Yes	No	Sensitivity to heat	Yes	No
Swelling or lumps in mouth	Yes	No	Sensitivity to cold	Yes	No
Biting cheeks or lips	Yes	No	Sensitivity to sweets	Yes	No
Difficulty or pain to open or close jaw	Yes	No	Sensitivity to biting	Yes	No
Clicking or popping jaw joints	Yes	No	Trapping food between teeth	Yes	No
Daily headaches	Yes	No	Clenching or grinding at night	Yes	No
Broken teeth	Yes	No	Clenching or grinding during the day	Yes	No

These things are important to me concerning my dental health:

- | | |
|---|---|
| (a) Currently, my mouth is very comfortable | (a) I have always done the best that was recommended for my dental health |
| (b) Currently, my mouth is moderately comfortable | (b) I have not always done what dentists recommended for my mouth |
| (c) Currently, my mouth is uncomfortable | (c) I rarely go to a dentist, and don't care much about having my dental work completed |
| (a) I think the appearance of my mouth is excellent | (a) I have put dentistry for myself and my family high on my priority list |
| (b) I am satisfied with the appearance of my mouth | (b) I have put dentistry for myself and my family low on my priority list |
| (c) I am dissatisfied with the appearance of my mouth | (c) Dentistry isn't on my priority list anywhere |
| (a) It is very important to keep all of my natural teeth | (a) I think my present state of dental health is excellent |
| (b) It is moderately important to me to keep my teeth | (b) I think my present state of dental health is good |
| (c) It is not important to me to keep my teeth | (c) I think my present state of dental health is poor |
| (a) I have set goals for my oral health with a previous dentist | |
| (b) I want to set goals concerning my oral health | |
| (c) I never set goals concerning my oral health and don't want to | |

My goals for my oral health are: _____

Dr. Thomas Barton D.D.S
2109 NE 72nd Street #102
Gladstone, Mo 64118

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

Patient #: _____ Social Security # _____

SECTION B: TO THE PATINET- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY. Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practice before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in out Notice of Privacy Practices. If we change our privacy practices, we will issue revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your proceed health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, Including any revisions of our Notice at anytime by contacting.

Dr. Thomas F. Barton D.D.S
2109 NE 72ne Street, Ste #102
Gladstone, Mo 64118
816-453-0195

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any actions we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents Of this Consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient. Complete the following:

Personal Representative's Name: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed consent in the patient's chart.

FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office, and to let you know we are committed to providing you with the best possible care for your individual needs. So there is no misunderstanding as to what our financial policy is, please take time to read the following information.

If you **do not** have insurance benefits, **full payment will be due the same day services are rendered.** To assist you we accept Cash, Checks, MasterCard, Visa and Care Credit.

If you have insurance benefits we will file insurance claims as a courtesy to our patients. **Please be advised that your dental insurance is a contract between you and the insurance company** and your coverage is determined by your employer. All services we recommend for you may not be covered by your plan. Reimbursement rates vary widely between companies and we cannot predict exactly how much any given insurance policy will pay. **You will be responsible for payment of deductibles, co-pays, and/or uninsured expenses in full the day services are rendered. Any remaining balances not paid by your insurance company after 60 days will be billed to you and considered your responsibility.**

Accounts are considered past due at 60 days from the date of service and at 90 days the outstanding balance will be sent to a collection agency.

You will be provided with an **estimated** cost of treatment so you will be aware of any copay amount due on the day of service. We encourage you to communicate with us regarding any difficulties you might have in meeting your financial obligations.

Time is set aside specifically for you when you make an appointment therefore, a minimum of (1) business day notification is required if you are unable to keep your appointment. Patients canceling without (1) day notice or who do not show up for their appointment will be charged a broken appointment fee of \$25.00 _____ please initial.

By signing below, you acknowledge your understanding of and agreement of these terms.

Signature or Patient of responsible party

Print Name

Date