# 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 ____________________________________________________________ Perferred 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)**

| | | | | | |
|---|---|---|---|---|---|
| ____ | Acrylic | ____ | Erythromycin | ____ | Sedatives |
| ____ | Aspirin | ____ | Jewelry / Metals | ____ | Sulfa drugs |
| ____ | Barbiturates | ____ | Latex | ____ | Tetracycline |
| ____ | Codeine | ____ | Penicillin | ____ | Other |
| ____ | Dental local anesthetics | | | | |

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

| | | | | | |
|---|---|---|---|---|---|
| ____ | AIDS / HIV | ____ | Fainting / dizziness | | |
| ____ | Acid reflux | ____ | Frequent headaches | ____ | Mitral valve prolapse |
| ____ | Anemia | ____ | Glaucoma | ____ | Psychiatric care |
| ____ | Angina | ____ | Hay fever / allergies | ____ | Radiation treatments |
| ____ | Arthritis | ____ | Heart attack / heart failure | ____ | Renal dialysis |
| ____ | Artificial joint | ____ | Heart murmur | ____ | Rheumatic fever |
| ____ | Asthma | ____ | Heart pacemaker | ____ | Rheumatoid arthritis |
| ____ | Blood disease | ____ | Hemophilia | ____ | Scarlet fever |
| ____ | Cancer | ____ | Hepatitis | ____ | Shingles |
| ____ | Chemotherapy | ____ | Herpes | ____ | Sickle cell anemia |
| ____ | Chest pains | ____ | High blood pressure | ____ | Sinus trouble |
| ____ | Cold sores / fever blisters | ____ | Hives or rash | ____ | Stomach / intestinal disease |
| ____ | Congenital heart disorders | ____ | Irregular heartbeat | ____ | Stroke |
| ____ | Cortisone medication | ____ | Kidney problems | ____ | Thyroid disease |
| ____ | Diabetes | ____ | Leukemia | ____ | Tumors or growths |
| ____ | Drug addiction | ____ | Liver disease | ____ | Tuberculosis |
| ____ | Emphysema | ____ | Low blood pressure | ____ | Ulcers |
| ____ | Epilepsy or seizures | ____ | Lung disease | ____ | Venereal disease |
| ____ | Excessive bleeding | ____ | Lupus | ____ | Yellow jaundice |
| ____ | 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
(b) Currently, my mouth is moderately comfortable
(c) Currently, my mouth is uncomfortable

(a) I think the appearance of my mouth is excellent
(b) I am satisfied with the appearance of my mouth
(c) I am dissatisfied with the appearance of my mouth

(a) It is very important to keep all of my natural teeth
(b) It is moderately important to me to keep my teeth
(c) It is not important to me to keep my teeth

(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

(a) I have always done the best that was recommended for my dental health
(b) I have not always done what dentists recommended for my mouth
(c) I rarely go to a dentist, and don't care much about having my dental work completed

(a) I have put dentistry for myself and my family high on my priority list
(b) I have put dentistry for myself and my family low on my priority list
(c) Dentistry isn't on my priority list anywhere

(a) I think my present state of dental health is excellent
(b) I think my present state of dental health is good
(c) I think my present state of dental health is poor

My goals for my oral health are: ____________________

______________________________________________________________________________________

**Dr. Thomas Barton D.D.S**
**9592 N. McGee Street**
**Kansas City, Mo 64155**

**SECTION A: PATIENT GIVING CONSENT**

**Name:** ______________________________________________________________________________

**Address:** ____________________________________________________________________________

**Telephone:** __________________________________________________________________________

**Patient #:** ______________________________ **Social Security #** ________________________________________

**SECTION B: TO THE PATIENT- 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.

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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 your 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