The Dentist

1010 Downing Avenue #10 Hays, Kansas 67601 785-625-6001

New Patient Adult Information

Name: ______________________________
Last First M

Preferred Name: ______________________________

Birth date: ___/___/___ __M __F __O

Address: ______________________________

City: ______________________________

State: ______________ Zip: ______________

Hm #: ______________ Cell #: ______________

Email: ______________________________

SSN: ______________________________

Employer: ______________________________

Work #: ______________

Person Responsible for Account
(If different than yourself)

Name: ______________________________
Last First M

Billing Address: ______________________________

City: ______________________________

State: ______________ Zip: ______________

Hm #: ______________ Cell#: ______________

Relation: ______________ Birth date: ___/___/___

SSN: ______________________________

Employer: ______________________________

Work #: ______________

Are you on Medicare: ____Y _____N

Alternate contact/in case of emergency/
Permission to release information

Name: ______________________________

Relation: ______________________________

Phone #: ______________________________

Name: ______________________________

Relation: ______________________________

Phone #: ______________________________

____ **I have received or reviewed a copy of this office's Notice of Privacy Practices.**

Signature: ______________________________ **Date:** ______________

The Dentist

Patient(s) Name(s): ____

As a condition of treatment by this office, I agree that payment is due on the day of service. If care is being given to a child the person who signs the papers is responsible for the payment on the account. If you do not wish to pay then you must have the responsible party sign the papers for the child's care. Financial arrangements must be made in advance of treatment being rendered. A courtesy statement of changes will be sent when insurance benefits have been paid. A $30.00 service charge will be added on all returned checks. All delinquent accounts will be turned over to a collection agency and additional fees will be applied.

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. 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. Insurance benefits are decided on by you and your employer and we are not a party to those decisions. 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, you are responsible for all costs incurred should your insurance company deny benefits to you. I understand that any fee estimates for dental care are an estimate and are subject to change without notification. We do use outside companies for no interest loans, please inquire if you are interested.

Each appointment is valuable and reserved for you. We will try to give a courtesy reminder text, email, or call but are under no obligation to remind you of your appointment. We require 48 hours notice to cancel a new patient appointment and 24 hours notice to cancel all other appointments. **A $25 fee will be assessed to reschedule should you cancel with less than 24 hours notice. Should you fail to call and cancel an appointment and then not show, a fee of $25 per 30 minutes rounded up will be assessed to reschedule.** As no shows and cancellation affect all of our patients, we reserve the right to dismiss patients that do not keep their appointments.

As a courtesy to patients and staff please turn off your cell phone while in the office. Absolutely no children are allowed in the treatment rooms while treatment is being rendered to a parent or sibling.

I grant my permission to you or your assignee, to contact me by telephone at home, cell or work, send postcards and letter to my home and work, by text messaging, and by email if one is given, to discuss my treatment needs, appointments, account balance or any other discussions that are necessary. I also grant permission to contact my alternate contact (if one is given) in case that my phone is out of service or to help locate me should I move. I give my consent for routine dental procedures and diagnostic tests, clinical photographs of my face and oral cavity, fluoride, and radiographs (x-rays) that are deemed necessary in the dentist's professional judgment. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is any change in my health I will inform the doctor or hygienist at the next appointment without fail. My signature below will also serve as signature on file for assignment of insurance benefits to be paid directly to the dentist. I acknowledge that I have read the above conditions of treatment and payment and I agree to their content.

Signature: ____ **Date:**________________

Relationship to Patient:
___Self ___Parent ___Guardian ___Grandparent ___Foster Parent

Adult Health History

Name: ____________________________ DOB: __________________

Name and phone number of medical doctor: ____

Is the patient currently under the care of a doctor for a medical condition? If pregnant when is their due date.

____

Please list ALL allergies and the reaction that occurs (rash, upset stomach, hives, hyperactivity, anaphylactic shock. ____

____

List ALL over the counter and prescription medications (include vitamins, herbal supplements, and recreational drugs): ____

____

Has the patient been hospitalized, had any surgeries or needed emergency care? Please explain:

____

____

Has the patient ever had any of the following? Please **circle** all that apply:

ADD/ADHD	Anemia	Angina	Arthritis	Artificial Joints	Asthma	Autism/ASD
Cancer	Cerebral Palsy	Chemotherapy	Cold Sores	Coumadin	Diabetes	Dizziness
Down's Syndrome	Epilepsy	Glaucoma	Head Injury	Heart Attack	Heart Problem	HIV/Aids
Latex Allergy	Liver Disease	Mental Disorder	Milk Allergy	Pacemaker	Radiation	Rheumatism
Stroke	Tuberculosis	Tumors	Ulcers	Developmental Delay	Hepatitis A, B, C	High Blood Pressure
Jaundice (not at birth)	Intellectual Disability	Muscular Dystrophy	Respiratory Problems	Rheumatic Fever	Bacterial Endocarditis	Other:

Any other medical conditions or problems not listed above? ______________________________

Have you been told by a medical doctor to take an antibiotic prior to dental treatment? If yes, why?

____

Tell us about any complication or bad dental experiences the patient has had following dental treatment or any problems with their teeth. ____

Has the patient ever been given any of the following bisphosponate drugs (common in cancer treatment and bone regrowth therapies)? Examples: Aredia (pamidronate), Zoledronate (Zometa, Aclasta), Bonefos (clodronate), Risedronate (Actonel), Ibandronate (Boniva), Neridronate, Olpadronate, Alendronate (Fosamax), Skelid, Didronel ____

____

How many 8 oz glasses of sugar-containing liquid or pop does the patient drink per day? Does the patient guzzle or sip them? ____

Does the patient use any tobacco products, if yes what kind and how much? ____________________________

Signature: ______________________________ Date: ________________________

Relationship to Patient:

__Self __Parent __Guardian __Grandparent __Foster Parent