******Please Turn Off Your Cell Phone******

Kelly B. Deines, DDS
Donna N. Deines, DDS
General Dentistry

Confidential Patient Information

Date_____

Patient's Name_____
(Last) (First) (Initial) (Nickname)

Soc. Sec. #_____ Date of Birth_____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Address _____
Apt._____

City _____State_____ Zip_____

Home Phone _____ Cell_____

Work_____ EMail_____

I prefer to be contacted by: ____Home ____ Cell ____Work ____E-Mail

Employer_____

Referred by_____

Emergency Contact _____ Phone_____

Person responsible for paying the account*_____

Address_____

Phone#_____Relationship_____SS#_____

Is the patient currently enrolled as a full-time student? Yes ☐ No☐

School Name and Location_____ Graduation date_____

***If the patient is a minor child, the parent that accompanies the child to the office will be responsible for paying the account.**

Does the patient have Dental Insurance to help pay for the appointment today? Yes☐ No ☐

****If the patient does not have insurance, full payment is expected at the time of service. ****

(Over)

Insurance Information

We will gladly file your insurance claim as a courtesy, but any outstanding balance after 60 days will become the patient's responsibility.

Please provide front and back copy of insurance card(s) **OR** complete the requested information below.

Primary Dental Insurance Information

Dental Insurance Company Name_____

Claims mailing address_____

_____

Insurance Company phone#_____

Website_____

Name of Cardholder_____

Cardholder's SS#_____

Cardholder's date of birth_____

Cardholder's employer_____

Group #_____ ID#_____

Secondary Dental Insurance Information (if any)

Dental Insurance Company Name_____

Claims mailing address_____

_____

Insurance Company phone#_____

Website_____

Name of Cardholder_____

Cardholder's SS#_____

Cardholder's date of birth_____

Cardholder's employer_____

Group #_____ ID#_____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ITEM 070-5962/25950 © MAY 2002

KELLY B. DEINES, D.D.S.
DONNA N. DEINES, D.D.S.
203 EAST 63RD STREET
KANSAS CITY MO 64113

(816) 333-8400

FINANCIAL POLICY

We are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today. In order to assist you with your health care investment, we provide the following payment options:

Payment is expected at the time services are rendered unless you have provided our office with dental insurance information.

Payment Option

1. **Cash**—includes money orders and personal checks.

2. **Visa/MasterCard/Discover**—we accept credit cards as payment for treatment to the extent of credit limit permits.

3. **CareCredit**—offers a separate line of credit to cover your entire family's dental care needs. A credit line can be established and approval usually takes less than 10 minutes.
   - CareCredit has interest free options: 3 months, 6 months, 1 year
   - There is no annual or membership fee
   - Monthly payments as low as 3% of the outstanding balance.

   Financing your treatment will allow you to begin your treatment immediately and spread the cost over a period of time.

Initial Payments for Major Services *(Dentures, Implants, Crowns & Bridges)*

Our office requires the following down payments at the start of treatment and balance when treatment is completed:
- 25% if you have insurance
- 50% if you do not have insurance
- A down payment is not required with CareCredit financing. When treatment is completed the fees will be applied to the CareCredit account.

INSURANCE

We will process your insurance claim. You will be responsible for any fees not paid by your insurance. Predetermination for services to insurance is done **at your request** prior to scheduling of treatment. **It is ultimately the insured's responsibility to know his/her dental plan and benefits.**

We are happy to work with you to plan the most appropriate arrangements for your budget.

Kelly Deines, DDS
Donna Deines, DDS