Moundridge Dental Center

324 E 2nd St. • Moundridge, KS 67107-7164 (620)345-2100

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work
☐ Insurance Website ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

Spouse or Responsible Party Information

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

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Secondary Dental Insurance

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Response Date: ___/___/_____

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Medical & Dental History Form

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam? Your Primary Care Physician's name, address, and phone number:

_____

_____

Are you currently taking any prescription or non-prescription medications? If so, please list.

_____

_____

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you require the use of corrective lenses (contacts or glasses)?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

Please indicate if you have or ever experienced any of the following.

- ☐ *Pre-Med - Amox
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ Kidney Disease
- ☐ Other
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Ulcers
- ☐ *Pre-Med - Clind
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Cancer
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Venereal Disease
- ☐ *Pre-Med - Other
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artificial Joints
- ☐ Chemo Therapy
- ☐ Epilepsy
- ☐ Hay fever
- ☐ Hepatitis A
- ☐ HIV
- ☐ Mental Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ Allergies
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Asthma
- ☐ COPD
- ☐ Excessive Bleeding
- ☐ Head Injuries
- ☐ Hepatitis B
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tumors

Are you pregnant? ◯ Yes ◯ No

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

_____

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

_____

Response Date: ___/___/_____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are commited to your treatment being successful. The following is a statement of our financial policy. We require that you read and sign this prior to any treatment.

Full payment is due at the time of sevice. We accept cash, checks, debit card, Visa, Mastercard, Discover and American Express.

In the event that you apply for our In-House Financing, and are approved, any late payments will be assessed a $25.00 late fee for payments not received by their due date.

Treatment estimates are only estimates. We are commited to your estimate being as accurate as possible however, sometimes it is necessary for the estimate to change during the course of treatment.

I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed condition that may be recongnized only during the course of treatment. I understand that any associated fees are my responsibility.

INSURANCE

We will accept assignment of insurance benefits and file your dental claim for you. Your insurance policy is a contract between you and your insurance company. We are not part of that contract. We will do everthing possible to assist you in getting the proper reimbursement. Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the sevice is rendered. The balance is your responsibility whether your ins pays or not. Any patient recieving treatment is respondible for full payment. Any patient receving treatment during hours that insurance can't be verified is responsible for full payment. Should your account balance exceed 30 days an annual percentage rate of 18% will be applied.

INSURANCE AUTHORIZATION

I authorize and request my insurance company to pay directly to the dentist or the dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

FAILED APPOINTMENTS

There will be a $35.00 charge for failed appointments. If you need to reschedule an appointment, we require 24 hours notice. If you fail three appointments, we reserve the right to dismiss you as a patient.

I have read the HIPAA, financial and insurance policies above. I understand and agree to the financial and insurance policy.

Signature _____ **Date** _____

Response Date: ___/___/_____

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*** You may refuse to sign this acknowledgement***

I have recieved a copy of this office's Notice of Privacy Practices

Signature _____ **Date** _____

For Office Use Only

We attempted to obtain written acknowledgement of reciept of our Notice of Privacy Practices, but acknowledgement coud not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us form obtaining acknowledgement
- ☐ Other (please specify)