

Patient Registration

Patient First Name: _____ MI _____ Patient Last Name: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Primary Contact Number: _____ Alternative Contact Number:; _____

Patient DOB: _____ Soc. Sec. # _____ Sex: Male ___ Female ___

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___ Separated ___

Email: _____

Emergency Contact Person and Number: _____ Relationship _____

Is the Patient the Insurance Policy Holder? Yes ___ No ___ , **If not please complete the following section.**

Primary Insurance Policy Holder:

Policy Holder First Name: _____ Policy Holder Last Name: _____

Policy Holder Address: _____ City: _____ State: _____ Zip: _____

Policy Holder Phone Number: _____ Policy Holder DOB: _____

Policy Holder Soc. Sec. # _____

Secondary Insurance Policy Holder:

Policy Holder First Name: _____ Policy Holder Last Name: _____

Policy Holder Address: _____ City: _____ State: _____ Zip: _____

Policy Holder Phone Number: _____ Policy Holder DOB: _____

Policy Holder Soc. Sec. #: _____

Primary Insurance Information:

Insurance Company Name: _____ Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Information:

Insurance Company Name: _____ Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Health History Update

Today's Date: _____

Patient's Name: _____

D.O.B: _____

Primary Care Physician: _____

Phone # _____

Are you currently under medical care? Yes ___ No ___

Have you ever had any serious illness or operation? Yes ___ No ___ Describe: _____

Do you smoke? Yes ___ No ___ Do you use chewing tobacco? Yes ___ No ___

Do you take a routine antibiotic before dental appointments? Yes ___ No ___

Have you ever had an allergic reaction to:

Local anesthetics? Yes ___ No ___ Penicillin or any other antibiotic? Yes ___ No ___

Sulfa drugs? Yes ___ No ___ Sedatives? Yes ___ No ___ Iodine? Yes ___ No ___

Aspirin? Yes ___ No ___ Other (not listed)? _____

Women Only!

Pregnant? Yes ___ No ___ How many weeks? _____ Nursing? Yes ___ No ___

Taking contraceptive pills? Yes ___ No ___ Are you currently or have you ever under went treatment for Osteoporosis? Yes ___ No ___

Please list below any medications you are taking including any over the counter medications or supplements, please attach a list of medications if needed.

1	2
3	4
5	6

Please Circle if you have or had any of the following medical conditions:

Aids/HIV	Cancer	Head Injury	Kidney Disease	Radiation	Blood disease
Chemo	Anemia	Heart disorder	Liver Disease	COPD	Heart Attack
Blood Disorder	Heart Murmur	Rheumatic Fever	Stroke	Arthritis	Fainting
Hepatitis-Type?	Sinus Problems	Blood Transfusion	Diabetes	Joint Replacement	High Blood Pressure
Lung Disease	Tuberculosis	Herpes/Fever Blisters	Epilepsy/Seizures	Excessive Bleeding	Asthma
Cardiac Pacemaker	Anxiety	Psychiatric care	Thyroid Conditions	Other (not listed)	Respiratory problems

Patient Signature: _____ **Date:** _____

Kaw Valley Family Dental
10601 Kaw Drive
Edwardsville, KS 66111

NO SHOW/CANCELLATION POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide us with a notice of more than 24 Business Day Hours. This will enable us to schedule another patient who also needs our time and care.

Office appointments which are cancelled with less than 24 Business Day Hours notification may be subject to \$25 cancellation fee.

Patients, who do not show up to their appointment and fail to call and cancel, will be considered a NO SHOW.

Patient Name(Please Print): _____

Signature: _____

Date: _____

Kaw Valley Family Dental
10601 Kaw Drive, Kansas City,KS 66111
Dr. John McKnight DDS
Dr. Ricky Atchison DDS
Dr. Joe Wittig DDS

Insurance and Financial Policy

At Leavenworth Family Dental, we believe that you deserve the best care. That's why we always present to you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know.

- Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion o your dental care. It is only meant to assist you.
- We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change;therefore it is impossible to give you a guaranteed quote at the tie of service. We estimate your portion based on the most up to date information we have, but is **only an estimate**. If you would like to know your insurance benefit, we will be happy to file a " pre treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does not delay treatment but will give you the exact out of pocket figures you may inquire.
- We will bill your insurance as a courtesy. If insurance does not pay within 90 days,Leavenworth Family Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance company you have is a legal contract between **you** and your insurance company. Our office is not,and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.
- Leavenworth Family Dental does require payment in **full** for your portion at the time of service. We accept all major forms of credit/debit cards,cash or check. If you are in need of an extended finance option, we also work with Care Credit "same as cash" or longer terms with interest bearing revolving chargers designed to meet your treatment plan needs on approved credit. Pre-payment **Will Be** required for specific treatment procedures.
- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **24 hour notice**. For the first offense a letter will be sent,and for any recurring offenses a \$50.00 cancellation fee **will** be charged, and possible dismissal from the dental practice.

I agree with the above conditions.

Print patient name: _____

Patient signature: _____

Date: _____

Kaw Valley Family Dental Privacy and HIPPA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____

Kaw Valley Family Dental Authorization and Release

I give authorization and permission to confirm appointments, discuss account information or medical/dental diagnosis via the following option (s) please select all that apply. Please list any person(s) with whom we may discuss these with as well, if none please check the " none" box, this applies to any person(s) 18 years or older. I certify that I have read and understand the above to the best of my knowledge. The above questions have been answered to the best of my knowledge. I understand false information can be dangerous to my health. I authorize the dentist to release information including diagnosis and records of treatment including account information that have been rendered to third party payers/or health care practitioners. I authorize and request my insurance company to pay directly to the dental office or dental group insurance 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 mine or child's behalf.

text Call home Call cell Call work. E-mail: _____ None:
(don't discuss with anyone other than myself?)

Name (of person we may discuss appointments/treatment or accounts with): _____

Relationship to Patient: _____ Phone Number _____

Signature of Patient: _____ Print Patient Name: _____ Date: _____