OVERLAND PARK
DENTAL DESIGN

(913) 451-7330 • Fax (913) 451-7336
4601 West 109th Street, Suite 318
Overland Park, KS 66211

Personal Information - Health History

Name _____ Birthdate _____ Social Security No. _____

Address _____
Address City State Zip

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Whom May We Thank for Referring You to Our Office? _____

Phones Home _____ Cell _____ Work _____

Email _____

In Case of Emergency, Who Should be Contacted? _____ Phone _____

Employer & Address _____

Spouse's Employer & Address _____

Account/Insurance Responsibility if someone other than yourself: _____

Name _____ Birthdate _____

Mailing Address: _____ Their Social Security # _____

Health History

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Anemia	☐ Cough, Persistent	☐ HIV/AIDS	☐ Skin Rash
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ Jaw Pain	☐ Stroke
☐ Artificial Heart Valves	☐ Diabetes	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Artificial Joints	☐ Epilepsy	☐ Liver Disease	☐ Thyroid Problems
☐ Asthma	☐ Fainting	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Back Problems	☐ Glaucoma	☐ Pacemaker	☐ Tonsillitis
☐ Blood Disease	☐ Headaches	☐ Psychiatric Care	☐ Tuberculosis
☐ Cancer	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Chemical Dependency	☐ Heart Problems	☐ Respiratory Disease	☐ VD, Herpes
☐ Chemotherapy	☐ Hemophilia	☐ Rheumatic Fever	
☐ Circulatory Problems	☐ Hepatitis	☐ Scarlet Fever	
☐ Cortisone Treatments	☐ High Blood Pressure	☐ Shortness of Breath	

Describe checked areas in more detail: _____

Primary Care Physician: _____ Phone: _____

List any and all ALLERGIES: _____

List any and all DRUGS/MEDICATIONS you are taking: _____

List any and all SURGERIES: _____

Are you being treated by a Doctor now? ☐ Yes ☐ No If yes, who? _____

The above information is true and correct to the best of my knowledge:

Patient Signature: _____

Date: _____

OFFICE USE ONLY
REVIEWED BY

_____ _____
Initials Date

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Getting To Know You

Name_____ Date_____

What name would you like us to call you?_____

Please describe the reason for your visit today:_____

_____

_____

How long has this been going on and what other events apply to today's visit?_____

_____

_____

Why have you decided to deal with this now?_____

_____

Have you consulted any other dentist about this? ☐ Yes ☐ No If yes, what was discussed or done?

_____

_____

When was your last dental evaluation?_____

Who is your previous or regular dentist?_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:_____

Have you noticed or has any dentist or hygienist ever said that you:

- ☐ Have gum disease (gingivitis)
- ☐ Grind your teeth
- ☐ Clicking or popping jaw
- ☐ Jaw pain or tiredness
- ☐ Pain around ear
- ☐ Lip or cheek biting
- ☐ Loose or broken teeth or fillings
- ☐ Food collection between teeth
- ☐ Sores, blisters or growths
- ☐ Bad breath
- ☐ Sensitivity to: _____cold _____heat _____sweets _____when biting or chewing

Would you like to know your options for:

☐ Improving your smile ☐ Looking younger ☐ Keeping your teeth

What are your priorities and what would you like to see done now?_____

_____

_____

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Consent For Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services performed without previous financial arrangements must be paid for at the time services are performed.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate for my dental care can only be extended for a period of 1 year from the date of the patients evaluation.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing (?) credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Signature of guarantor of payment/responsible party Relationship to Patient

Insurance Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Please print name of Patient, Parent or Guardian Relationship to Patient

Digital Photo Authorization

I certify that my dentist may use my digital photos and may disclose such information to my insurance company or for consultation with any other health care professional in seeking best care options.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Please print name of Patient, Parent or Guardian Relationship to Patient

Notice of Privacy Practices & HIPAA Consent

Patient Privacy is important to our practice. We are required by law to maintain privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk).

You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

* Protected health information may be disclosed or used for treatment, payment or health care operations
* The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
* The Practice reserves the right to change the Notice of Privacy Policy.
* The patient has the right to restrict the use of their information.
* The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
* The Practice may condition receipt of treatment upon the execution of this Consent.

Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name:_____

Name:_____

Name:_____

_____

This HIPAA Consent/Sharing was signed by Date

_____

Relationship to Patient (if other than patient):