WELCOME

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

Is patient covered by secondary insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext_____ Alt. (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Work Phone (_____) _____ Ext_____ Alt. Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

How often do you floss? _____

How often do you brush? _____

Do you wear contact lenses? ☐ Yes ☐ No

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Phone (_____) _____ Pharmacy _____ Phone (_____) _____

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

AIDS	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	**Have you ever had or been diagnosed with:**	
Chemotherapy	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Artificial Heart Valves	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Artificial Joints, Screws, Pins, etc.	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No	Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Congenital Heart Lesions	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No	Hernia Repair	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Special Diet/Weight Loss	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Hepatitis Type _____	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No		
Herpes	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No		

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

If yes, please describe _____

_____

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

If yes, please describe _____

_____

Women: Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Have you ever taken any of these medications?

Blood Thinners	☐ Yes	☐ No
Coumadin	☐ Yes	☐ No
Warfarin	☐ Yes	☐ No
Diet Medications	☐ Yes	☐ No
Dexfenfluramine	☐ Yes	☐ No
Fen-phen	☐ Yes	☐ No
Pondimin	☐ Yes	☐ No
Redux	☐ Yes	☐ No
Levoxyl	☐ Yes	☐ No
Synthroid	☐ Yes	☐ No

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Are you allergic to:

Aspirin	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Local Anesthesia	☐ Yes	☐ No
Metals (i.e. gold)	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No

Other _____

Please PRINT all medications now taking: _____

_____

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) 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 doctor 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize

Dr. ____w_____ (Name of Doctor Disclosing PHI) to use and/or disclose my Protected Health Information (PHI) related to _____ (Describe in detail the Protected Health Information you are authorizing to be used and/or disclosed). The information will be used and/or disclosed for the purpose of _____ (Describe each purpose for which you are authorizing your Protected Health Information to be used and/or disclosed). I authorize Dr. _____ (Name of Doctor Receiving PHI) to receive and use the information.

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

DOCTOR'S COMMENTS & UPDATE (to be completed by the dentist)

Medical Clearance Letter Sent to _____ Date _____

Results _____

Signature _____ Date _____

Family Dental Care, LLC
Dr. Erica Fisher, Dr. Kristy Fisher, and Dr. Amy Bagley
6300 N Revere, Suite 210
Kansas City, MO 64151
(816)505-9767

GENERAL CONSENT AND INFORMATION FORM

It is the belief of this office that you should be informed about the treatment (therapy) we may recommend, and that you should give your consent before starting that treatment. The purpose of this form is to advise of the risks that may occur in dental treatment and other treatment choices.

RISK OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (painkillers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness, and tingling sensations in the lip, tongue, chin, gums, cheeks, and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth, or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

CHANGES IN TREATMENT PLAN: I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes, additions and/or deletions as the dentist deems necessary.

RELEASE OF PROTECTED HEALTH INFORMATION: I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I understand that in order to receive proper care, it may be necessary to use my health care information for the purpose of obtaining insurance payment for services rendered, determining insurance benefits or the benefits payable for related services. I understand that there may also be a need to consult with other health care providers for the purpose of protecting my general health.

I hereby request and authorize Family Dental Care, LLC (Dr. Erica Fisher, Dr. Kristy Fisher, and Dr. Amy Bagley), and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function, and health of my mouth, teeth, bone, and tissues, and understand the risks involved, as well as the possible alternative methods of treatment that have been fully explained to me. I also authorize the operating dentist and assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve my condition, or treat unhealthy or unforeseen conditions that may be encountered during treatment.

I understand that dentistry is not an exact science, and therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I am requesting and authorizing. In order to receive treatment, I agree that if there is any difference or disagreement between my attending dentists and myself, all efforts will be made to resolve any difference or disagreement with my attending dentist and myself. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation board such as the grievance committee of my dental health plan, the Dental Society, or Missouri Dental Board and agree to accept their resolution in lieu of pursuing remedies by way of litigation, in consideration of helping to keep costs of treatment and services as low as possible. I also understand that this agreement is binding on my heirs and all other family members.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature_____ Date_____

Please Print Name_____

FAMILY DENTAL CARE FINANCIAL POLICY

Welcome to our dental practice! We are committed to providing you with the best possible dental care. We believe that service to our patients is at its best when there is understanding and mutual cooperation. It is important that you understand what is expected financially before any dental treatment. Please ask if you have any questions about our fees, financial policy, or your responsibility.

Payment is due at the time of your appointment. We accept cash, checks, Visa, MasterCard, American Express, Discover and Care Credit.

In most instances we accept assignment of insurance benefits, in which case, your portion of each treatment is due at your appointment. The patient portion will be an estimate based on the information given by a representative from the patient's insurance company. This information is NOT a guarantee of payment. We will assist you in any way possible to receive payment for charges filed with your insurance. Patients are responsible for all amounts not covered by their insurance carrier.

PLEASE UNDERSTAND THAT:

1. YOUR insurance is a contract between you, your employer, and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to the companies who pay a percentage of dental fees. However, this statement does not apply to companies who reimburse based on a fee schedule which bears no relationship to current standard cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. This may include procedures such as additional x-rays needed by your insurance company to process your claim.
4. Should your insurance company take longer than 60 days to pay, we would ask that you take care of the balance due and be reimbursed when we receive the insurance payment.
5. Should your account be sent to a collection agency for failure to pay, you will be responsible for your balance plus a 20% collection fee.
6. Returned checks are subject to a $30 fee.
7. Any unpaid balances over 60 days are subject to 9% interest.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are YOUR responsibility from the day services are rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems should arise, we encourage you to contact us promptly for assistance in the management of your account.

This is a policy for all our patients and will help keep our fees more stable. If at any time you have a question or are unhappy about any treatment, fee, or service, please discuss it with us promptly and openly. We are here to help you and look forward to providing you with excellent dental care!

Thank you,
Dr. Erica Fisher, Dr. Kristy Fisher, and Dr. Amy Bagley

Responsible Party Signature_____Date_____

Print Name_____