WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form as completely as possible. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Name _____ Date: _____

Birthdate _____ Email _____

Soc. Sec. # _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State _____ Zip _____

Home Phone _____ Emergency Phone _____

Referred by _____

Other immediate family members who are active patients in our office _____

2 Responsible Party

Who is responsible for the account? Is this person currently a patient in our office? ☐ Yes ☐ No

Name _____

Relationship to patient _____ Email _____

Birthdate _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Alternate Phone _____

Is the patient covered by Medicaid? ☐ No ☐ Yes Medical Card # _____

3 Family Employment / Insurance Information

Responsible Party Employment/Insurance

Name of Employee _____

Relationship to Patient _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Work Phone _____

Insurance Information

Dental Insurance Co. _____

Group # _____ Employee/ID # _____

Ins. Co. Address _____

City _____ State _____ Zip _____

☐ Primary Insurance ☐ Secondary Insurance

Additional Employees/Insurance

Name of Employee _____

Relationship to patient _____

Birthdate _____

Soc. Sec. # _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Work Phone _____

Insurance Information

Dental Insurance Co. _____

Group # _____ Employee/ID # _____

Ins. Co. Address _____

City _____ State _____ Zip _____

☐ Primary Insurance ☐ Secondary Insurance

Office Privacy and Security

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, _____
have read this office's Notice of Privacy Practices.

A printed copy of the Notice was offered to me by the staff and I

_____ accepted _____ declined

_____
Please Print Name

_____
Signature

_____
Today's Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be secured because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining the acknowledgement

_____ Other (please specify) _____

_____ Team Member Initials _____ Date

Thank you for choosing our office for your dental care and filling out this form completely. The information you have provided will help us serve your oral healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.

FORM 016651 R/06/11 ITEM 8101

Please identify any allergic reactions:

☐ None ☐ Sedatives or barbiturates
☐ Local anesthetics, like novocaine
☐ Penicillin ☐ Cephalexin
☐ Sulfa ☐ Erythromycin
☐ Aspirin ☐ Latex
☐ Other: _____

Have you been hospitalized or needed emergency treatment in the past 2 years? Please explain:

_____

_____

Name of your physician(s):

_____

Do you have, or have you had any of the following:

Yes	No	
☐	☐	Joint replacement or implant
		Type: _____ Date: _____
☐	☐	Rheumatic heart disease or Scarlet Fever
☐	☐	Heart defect or murmur
		Explain: _____
☐	☐	Heart disease, heart attack, chest pain
☐	☐	Pacemaker
☐	☐	Heart surgery Date: _____
☐	☐	Need for dental "premedication"
☐	☐	Blood pressure problems ☐ High ☐ Low
☐	☐	AIDS or HIV infection
☐	☐	Hepatitis or other blood disease
☐	☐	Bleeding/Clotting disorders
☐	☐	Sexually transmitted disease
☐	☐	Thyroid problems
☐	☐	Epilepsy/Convulsions
☐	☐	Nervous disorder
☐	☐	Rheumatism or Arthritic disease

Please identify any current dental problems:

☐	☐	Gums bleed with brushing/flossing
☐	☐	Sensitivity to hot/cold foods
☐	☐	Pain in any of your teeth
☐	☐	Sores or lumps in or near your mouth

What would you like to change about your teeth or smile? circle: Brightness Tooth color
Crowding Chipped or cracked teeth Missing teeth
Other: _____

List the names of all your current medications:

☐ **None** _____

_____

_____

_____

_____

Do your medications include the following:

☐ **Yes** ☐ **No** Blood thinners (including daily aspirin)
☐ **Yes** ☐ **No** Bisphosphonates (bone density drugs)

Women only:	**Yes**	**No**
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

Continue to list if you have had any of the following:

Yes	No	
☐	☐	Tuberculosis
☐	☐	Breathing problems or asthma
☐	☐	Persistent cough
☐	☐	Liver disease or jaundice
☐	☐	Anemia
☐	☐	Diabetes
☐	☐	Stroke
☐	☐	Cancer (Type/Date) _____
☐	☐	Chemotherapy
☐	☐	Radiation therapy
☐	☐	Glaucoma
☐	☐	Kidney disease Dialysis ☐ Yes ☐ No
☐	☐	Stomach trouble/ulcers
☐	☐	Sinus trouble/seasonal allergies
☐	☐	Other: _____
☐	☐	Do you smoke or chew tobacco?

Patient Name: _____

Signature: _____

Relationship: _____ **Date** _____

Staff signature: _____

Notes: _____

_____

Terry L. Davidson, D.D.S., P.A.
606 N. Main St.
Newton, KS 67114
(316)283-0110

Appointment Cancelation Policy

If you arrive at our office more than 10 minutes after your scheduled appointment time, you may be asked to reschedule the appointment.

** We have reserved a specific time to spend with each patient. It is important to be on time for the visit so we can provide the best dental care possible during the time allowed for the services.
** We require a 24 hour cancelation notice for a scheduled appointment. Advanced notice of a cancelation allows us to schedule efficiently and see other patients who may be in need of dental care.
** For an individual patient or a family, we will allow 1 missed appointment (no show) without penalty; however, a second occurrence may incur a charge. Our office reserves the right to deny future treatment to those who demonstrate chronic disregard for attending scheduled appointments.

Patient Financial Policy

Our policy requires payment in full at the time of service for charges not covered by insurance.

If you are a member of a Dental Insurance Plan and have chosen us as your dental provider, it is your responsibility to:

** Provide us with information relative to your claim, including insurance card (if available), ID number/group number, employer, name of insured, date of birth, address and Social Security number. This information is requested on the Patient information form, which we ask that you complete during your initial visit.
** Alert our staff if the insurance information or coverage changes at any time.
** Pay your deductible or co-pay at the time of service.

Insurance claims for your dental services are filed as a courtesy at no charge to you. While we will certainly advocate on your behalf for proper payment of claims and will assist in explaining benefits whenever possible, it is your responsibility to understand the coverage available under the policy. Any denial of insurance benefits will not result in an adjustment of charges and the balance will be billed accordingly.

** To assist with your payment, our office accepts cash, check, Visa, MasterCard and Discover.
** Financing options are available through Care Credit and the Hutchinson Credit Union. Additional information about these plans is available from our office staff.
** We are providers for Delta Dental (Premier level), BCBS of KS and United Concordia. We also accept Kansas Medicaid for limited patient populations.
** A $30 overdraft charge will be posted to your account for any insufficient check.

We work very hard to make dental services available and affordable for all our patients, but it is your responsibility to attend to any outstanding balance in a timely manner. For accounts that are 60 days past due, a finance charge of 18% (annually) will be added to the balance. If your bill becomes 90 days delinquent without payment, the account will be turned over to collections. You will be informed of this action and it will be your responsibility to locate another provider for any future dental needs.

Terry L. Davidson, D.D.S., P.A.

606 N. Main St.
Newton, KS 67114
(316)283-0110

Consent Form

I hereby authorize, for the patient named below, examination and treatment by members of the team of Terry L. Davidson, D.D.S., P.A. and any assistants or designees deemed necessary by Dr. Davidson. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations in this office.

RELEASE OF INFORMATION

I authorize the release of information concerning (___my)(___my dependent's) office visit to (and/or) from the primary care physician, family physician, a dental specialist for referral or insurance company.

PHOTOGRAPHS

I authorize the taking of digital or intraoral photographs to be used for dental treatment planning.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I authorize payment of third-party benefits, (otherwise payable to me) directly to Terry L. Davidson, D.D.S., P.A., not to exceed the doctor's regular charges. I understand that I am financially responsible to the doctor for the patient indicated and I agree to pay Terry L. Davidson, D.D.S., P.A. all amounts incurred by the patient which are not covered by a third payer. I understand that this expense is due at the time of service.

APPOINTMENT AND FINANCIAL POLICY

I have read and fully understand the reverse side which informs about scheduling appointments and my financial responsibilities for services and the charges received in this office. By signing below I agree to the terms indicated.

_____ _____
Patient's Name **Date of Birth**

_____ _____
Printed Name of Responsible Party **Relationship**

_____ _____
Signature of Responsible Party **Today's Date**

Interpreter Consent

I, _____, read the above statement to _____ he/she understands and approves consent as stated above.

_____ _____ _____
Interpreter's Signature **Responsible Party Signature** **Today's Date**