pierce & knight
FAMILY DENTISTRY

Date

8615 Rosehill Road, Lenexa, KS 66215 | (913) 888-2882

Name | Home Phone

Address | Cell Phone

City/State/Zip | Work Phone

Email Address

Date of Birth ◯ Male ◯ Female

Social Security Number ◯ Married ◯ Single ◯ Widowed

Person responsible for account

Address (if different from your own)

Employer

Business Phone | Alternate Phone

Dental Insurance Company | Group #

Name of Policy Holder | Policy holder's date of birth

Policy holder's social security number or insurance ID number

If covered by more than one insurance policy:

Secondary Insurance Company | Group #

Name of Policy Holder | Policy holder's date of birth

Policy holder's social security number or insurance ID number

Whom may we thank for referring you to us?

Is your significant other a patient here? ◯ Yes ◯ No

If not, they should be! Should we contact him/her? ◯ Yes ◯ No

What is the reason for your visit today?

- ◯ Checkup
- ◯ Tooth ache
- ◯ Teeth or gums hurting / bothering me
- ◯ Other

When was the last time you were seen by a dentist for a cleaning?

When was the last time you were seen by a dentist for a complete dental exam?

Former Dentist's Name | City

How many times a day do you brush your teeth? | How many times a week do you floss?

What type of tooth brush do you use? ◯ Manual ◯ Electric

Do you wear removable dentures or partial dentures? ◯ Yes ◯ No

If yes, when were they placed?

Are you using any other dental devices (i.e. retainer, bite guard, snoring appliance, etc)?

Do you have any dental problems now or feel pain in any of your teeth? ◯ Yes ◯ No

If yes, please describe

Are your teeth sensitive to any of the following:

- ◯ Hot / Cold
- ◯ Sweets
- ◯ Biting / Chewing

Do you have any sores or lumps in or near your mouth? ◯ Yes ◯ No

Do your gums bleed while brushing or flossing? ◯ Yes ◯ No ◯ Sometimes

Does food tend to become caught in between your teeth? ◯ Yes ◯ No

Do you clench or grind your teeth? ◯ Yes ◯ No ◯ Not Sure

Do you bite your lips or cheeks frequently? ◯ Yes ◯ No

Do you hold foreign objects with your teeth ◯ Yes ◯ No
(i.e. pencils, pipes, nails, fingernails, etc.)?

Do you have tired jaws, especially in the morning? ◯ Yes ◯ No

Do you smoke or use tobacco? ◯ Yes ◯ No

Have you ever had orthodontic treatments ◯ Yes ◯ No
(i.e. braces, retainer, etc.)?

Have you ever had any of the following? If yes, please describe.

- ◯ Oral surgery
- ◯ Periodontal treatment
- ◯ Your bite adjusted
- ◯ Night guard
- ◯ Serious injury to the mouth or head

Have you ever experienced any of the following?

- ◯ Clicking or popping of the jaw
- ◯ Pain in joint, ear, side of face
- ◯ Difficulty opening or closing the mouth
- ◯ Difficulty chewing on either side of the mouth
- ◯ Headaches, neck aches, or shoulder aches
- ◯ Sore muscles

Have you ever had a difficult tooth extraction? ◯ Yes ◯ No

Have you ever had prolonged bleeding following an extraction? ◯ Yes ◯ No

Are you interested in doing cosmetic treatment? ◯ Yes ◯ No
(i.e. teeth whitening, veneers, straightening teeth, etc.)

Do you like your smile? ◯ Yes ◯ No

Is there anything about having dental treatment that you would like us to know? ◯ Yes ◯ No

If yes, please describe:

As it relates to my medical history, all of the preceding answers are true and correct to the best of my knowledge. If I ever have a change in my health, or if my medicines change, I will inform the doctors and the staff at my next dental appointment without fail. (Insurance patients only: I authorize release of any information relating to my dental insurance claims. I understand that I am responsible for all costs of dental treatment and that before credit is extended a credit report will be obtained.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

pierce & knight
FAMILY DENTISTRY

Medical History

Patient Name _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

As applicable, explain next to questions below; please use comments section if additional space is required:

Are you under a physician's care now?	◯ Yes ◯ No
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No
Have you ever had a serious head or neck injury?	◯ Yes ◯ No
Are you on a special diet?	◯ Yes ◯ No
Do you use tobacco?	◯ Yes ◯ No
Do you use controlled substances?	◯ Yes ◯ No
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Local Anesthetics ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa drugs

◯ Other If yes, please explain: _____

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

AIDS/HIV Positive	◯ Yes	◯ No	Cortisone Medicine	◯ Yes	◯ No	Hepatitis A	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis B	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Easily Winded	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No	Epilepsy or Seizures	◯ Yes	◯ No	Hives or Rash	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Excessive Bleeding	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Fainting Spells/Dizziness	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	Frequent Cough	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No	Stomach/Intestinal Disease	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Frequent Diarrhea	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Breathing Problem	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Hay Fever	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Cold sores/fever blisters	◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No	Parathyroid Disease	◯ Yes	◯ No	Yellow Jaundice	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No	Heart Trouble/Disease	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No			
Convulsions	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

List all medications: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

pierce & knight
FAMILY DENTISTRY

8615 Rosehill Road, Lenexa, KS 66215 | (913) 888-2882

Consent to Treatment

I understand that I will receive a dental examination today, and while I am a patient of this practice I will be given options for treatment. 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 examinations. I give my permission to Dr. Pierce and/or Dr. Knight to make any/all changes and additions as necessary.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot always fully guarantee results. I acknowledge that no guarantee or assurance has been made or will be made by anyone regarding the dental treatment that I will receive. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I give my consent to receive dental treatment at Pierce & Knight Family Dentistry.

Patient Name (print) _____

Signature _____

Relationship to Patient _____

Date _____

pierce & knight
FAMILY DENTISTRY

8615 Rosehill Road, Lenexa, KS 66215 | (913) 888-2882

Patient HIPPA Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ☑ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- ☑ Obtain payment from third-party payers
- ☑ Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (print) _____

Signature _____

Relationship to Patient _____

Date _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- ✓ ***Treatment*** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- ✓ ***Payment*** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- ✓ ***Health care operations*** includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- ✓ The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- ✓ The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- ✓ The right to inspect and copy your protected health information.
- ✓ The right to amend your protected health information.
- ✓ The right to receive an accounting of disclosures of protected health information.
- ✓ The right to obtain a paper copy of this notice from us upon request.

pierce & knight
FAMILY DENTISTRY

8615 Rosehill Road, Lenexa, KS 66215 | (913) 888-2882

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ☑ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- ☑ Obtain payment from third-party payers
- ☑ Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (print) _____

Signature _____

Relationship to Patient _____

Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this *Notice of Privacy Practices* Acknowledgment, but was unable to do so as documented below:

Date _____ Initials _____ Reason _____

pierce & knight
FAMILY DENTISTRY

8615 Rosehill Road, Lenexa, KS 66215 | (913) 888-2882

Your clear understanding of our office policies is important to our professional relationship, and we are pleased to discuss these policies with you at any time. Please feel free to contact us if you have any questions about our fees, financial policy and/or cancellation policy.

Financial Policy

☑ You are responsible for payment/co-pay at the time services are rendered. An adult who accompanies a minor is responsible for payment at the time services are rendered.

☑ We accept cash, checks, Visa, MasterCard, and Discover. We also offer no interest financing payment plans through Care Credit for qualified applicants.

☑ If you have dental insurance coverage, please check your dental benefits to see what types of services are covered. If there are changes to your insurance coverage, you are responsible for making us aware of these changes. We will file an insurance claim for you; however, your co-pay will be required at the time services are rendered. As a courtesy to you, we do accept assignment of benefit payment from most insurance companies but keep in mind your policy is a contract between you and your insurance company. We are not a party to this contract. We will not become involved in disputes between you and your insurance company regarding deductible, covered charges, secondary insurance, etc., other than to supply factual information as necessary. YOU ARE RESPONSIBLE FOR TIMELY PAYMENT OF YOUR ACCOUNT.

☑ We allow 30 days for your insurance company to make a payment. After that time, all inquiries or follow-up on payments due become your responsibility.

Cancellation Policy

☑ I understand that if I cancel less than 24 hours in advance, I will be charged a non-refundable cancellation fee of $50.00 per hour.

☑ If I do not show up for my appointment and do not call to cancel, I understand I will be charged a non-refundable cancellation fee $50.00 per hour.

☑ If I cancel short notice or miss multiple appointments, I understand I will be required to pay a $50.00 per hour deposit to secure another appointment. If that appointment is missed or cancelled short notice (less than 24 hours), that deposit will NOT be refunded. If the appointment is kept, the deposit will be applied toward that treatment.

☑ If you/your family has a continued problem (3 times or more) with missing or short notice cancelling appointments, we reserve the right to terminate our doctor—patient relationship.

Signature of Patient / Guardian _____ Date _____

pierce & knight
FAMILY DENTISTRY

8615 Rosehill Road, Lenexa, KS 66215 | (913) 888-2882

Electronic Signature Disclaimer

If you intend to electronically sign the Pierce & Knight Family Dentistry patient information, consent and policy statements, please read this carefully before signing.

By signing your name electronically on the prior documents listed below, you are agreeing that your electronic signature is the legal equivalent of your manual signature. A copy of these completed forms is available from our office upon request.

- ☑ Patient Information Form
- ☑ Medical History
- ☑ Consent to Treatment
- ☑ Patient HIPPA Consent Form
- ☑ Notice of Privacy Practices
- ☑ Financial & Cancellation Policies

Submit for Processing

To submit these forms to our office for processing, please complete one of the following actions:

E-MAIL: Compose an e-mail on your local device and attach a completed copy of these forms. Please send the e-mail directly to: pierceandknight@gmail.com

- OR -

PRINT: Print all completed pages enclosed in this information packet and bring them with you to your next appointment