

PATIENT REGISTRATION

ID: _____ Chart ID: _____
First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient is : Responsible Party Policy Holder

Patient Information:

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Female Male Marital Status: Married Single Divorced Separated Widowed

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

E-mail: _____ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: Full Time Part Time Self Employed Retired Unemployed

Student Status: Full Time Part Time

Preferred Dentist: _____ Preferred Hygienist: _____ Preferred Pharmacy: _____

Referred By: _____

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

Responsible Party is Policy Holder for Patient Primary Policy Holder Secondary Policy Holder

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Member ID: _____ Group ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Member ID: _____ Group ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ City, State, Zip: _____

LOVE TO SMILE

Complete Family & Implant Dentistry



Name: _____ Date: _____

How did you hear about our office? _____

What dental concerns do you have? _____

Have you ever had Periodontal Treatment (Deep Cleanings)? _____

Tell us about your previous dental visits? _____

What is the most important thing you want in a Dentist? _____

Are you happy with the shade of your teeth? _____

If there was one thing in your mouth that you could change, what would it be? _____

What factors have held you back from doing the work?

Motivators:

Fear _____

Money _____

Time _____

Other _____

Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

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

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

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

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

Have you ever had any serious illness not listed Yes No If yes

Comments:

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:

X _____

Date: _____

SYMPTOM EVALUATION QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____

Do you have any of the following symptoms:

- | | | |
|--|------------------------------|-----------------------------|
| Facial pain (G50.1) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Jaw pain or discomfort (R68.84) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neck pain (M54.2) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headaches (R51) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Migraine headache (G43.109) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bone loss/osteolysis (M89.58) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nasal congestion or sinus problems (J32.0) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle pain (masticatory muscle) (M79.11) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle pain (auxiliary muscle, head and neck) (M79.12) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle inflammation (M60.80) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ringling in the ears – Tinnitus (H93.19) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ear pain – Otagia (H92.09) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Facial swelling (R22.0) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sleep related (G47.33) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other symptom(s): _____

X

Signature of Patient or Legal Guardian

Date

Financial Agreement
PAYMENT OF COINSURANCE IS REQUIRED AT TIME OF SERVICE

If the patient does not have insurance, full payment is expected at the time of service unless other arrangements have been made prior to the date of the appointment.

Insurance companies pay benefits based on fees that they determine according to contracts negotiated with employers. Insurance is designed to **help** patients pay for the care they need. Please understand insurance may not pay for the entire fee and in some cases may not cover the service at all. If this should occur, the patient or their responsible party is liable for the balance not covered by insurance. Our goal is to provide the best possible care to our patients, and to do this we cannot let any insurance company dictate those guidelines. Patients who have dental insurance should remember that professional services are provided and charged to the patient or their responsible party, not the insurance company. We will attempt to obtain an estimate of covered fees from the patient's **primary** insurance carrier, and will require payment of any deductible or non-covered portion of the fee at the time of each appointment or before. If we are not able to obtain an estimate from the patient's insurance company before the time of service, we will require payment in full at the time of service. We will submit claims for secondary insurance only if the account is paid in full.

Auto checkout will be utilized for your convenience for amounts of \$75 or less _____ Please Initial

We will refund any overpayment to the responsible party. If after a refund is made, the insurance company determines that an insurance overpayment has resulted, you will be responsible for repaying the amount demanded by the insurance carrier. If a third-party financing option is used (Care Credit), refunds will be made directly to the third-party financial source.

We will submit insurance claims for the patient unless other arrangements have been made. Filing insurance claims from our office is a **courtesy** we extend to our patients- not an obligation. If the patient's insurance company requires predetermination of service, it is the patient's responsibility to notify our office sufficiently prior to the date of service to obtain that predetermination.

If the patient's insurance company's payment exceeds our estimate of their covered fees, the responsible party will be reimbursed for the paid amount. If the reimbursement is less than the estimate, the responsible party will be billed for the balance and payment in full is due upon receipt.

Sixty days will be allowed for the patient's insurance company to process the claim. **If, after sixty days, no notice has been received from the insurance company, the responsible party will be required to contact them directly and payment is due in full at this time. The account will be subject to a charge of 12% APR. Please note a \$35.00 fee will be assessed for all returned checks.** If any balance is overdue and legal and/or collection assistance becomes necessary, the responsible party will be liable for charges incurred. I understand the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

The parent that accompanies the child to the office will be responsible for the fees.

I give Love to Smile Dentistry permission to release any necessary records or x-rays to my insurance company or companies as needed.

This signature is on file as my authorization for the release of information necessary to process my claim. I hereby authorize payment to Love To Smile Dentistry of the insurance benefits otherwise due me.

Please be advised that we require at least 48 hours notice when rescheduling an appointment. There will be a \$75 fee for a missed appointment or cancellation with less than 48 hours notice. To cancel an appointment without proper notice prevents us from being able to offer this time to other patients. In addition, minimizing schedule changes allows us to not have to raise our fees. Auto checkout will be utilized for your convenience _____ Please Initial

I have read the above financial policy and agree to the terms outlined therein.

Patient/Parent or Legal Guardian _____ Date _____

LOVE TO SMILE DENTISTRY

10925 Antioch Rd, Suite 201, Overland Park, KS 66210 P: 913-491-1200

ACKNOWLEDGMENT FORM

Last Name First Name MI

Patient record#: _____

Date of Birth: ____/____/____

**ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY
PRACTICES**

We at Love to Smile Dentistry are required by law to maintain the privacy of our patients and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

By signing below, I am acknowledging that:

- I am either the patient or the patient’s personal representative;
- I have received a copy of the “Notice of Privacy Practices” for Love to Smile Dentistry and have reviewed the HIPAA Notice of Privacy Practice document; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Signature of patient or parent/legal guardian/legally responsible person Date

Description of relationship to patient

TO BE COMPLETED BY STAFF

Complete if signature requested but not obtained:

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient’s personal representative for the following reason:

- Patient/personal representative refused to sign form
- Other _____

Office Team Member

Date

LOVE TO SMILE DENTISTRY
10925 Antioch Rd, Suite 201, Overland Park, KS 66210 P: 913-491-1200

**Patient Consent for Use and Disclosure
of Protected Health Information**

I hereby give my consent for Love to Smile Dentistry to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Love to Smile Dentistry describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Love to Smile Dentistry reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Love to Smile Dentistry at 10925 Antioch Road, Suite 201; Overland Park, KS 66210.

_____ With this consent, Love to Smile Dentistry may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

_____ With this consent, Love to Smile Dentistry may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

_____ With this consent, Love to Smile Dentistry may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Love to Smile Dentistry restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Love to Smile Dentistry to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Love to Smile Dentistry may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Relationship to Patient

Print Patient's Name

Date

Print Name of Patient or Legal Guardian, if applicable