LOVE TO SMILE OnSite

First Name:_____ **Last Name:**_____ **MI:**_____

Preferred Name:_____ **Birthdate:** _____

Address:_____ **City/State/Zip:**_____ **Home**

Ph: _____ **Cell Ph:** _____**Work Ph:** _____

E-mail:_____

Social Security Number: _____

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

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Unemployed

Student Status: ○ Full Time ○ Part Time

Preferred Pharmacy: _____

Emergency Contact

Name: _____ **Relationship:**_____ **Ph:**_____

Primary Insurance Information	**Secondary Insurance Information**
Policy Holder:_____	**Policy Holder:**_____
Patient's Relationship to Policy Holder:	**Patient's Relationship to Policy Holder:**
○ Self ○ Spouse ○ Child ○ Other	○ Self ○ Spouse ○ Child ○ Other
Insurance Company:_____	**Insurance Company:**_____
Member/Subscriber ID:_____	**Member/Subscriber ID:**_____
Subscriber Social Security #:_____	**Subscriber Social Security #:**_____
Group #:_____	**Group #:**_____
Phone Number:_____	**Phone Number:**_____
Address:_____	**Address:**_____
_____	_____

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 that you may be taking, c

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	
Do you use controlled substances?	Yes No	If yes

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

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

Have you ever had any serious illness not listed above? 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:_____

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?

Fear _____

Money _____

Time _____

Other _____

10925 Antioch Rd. · Overland Park, KS 66210
P: 913.491.1200 F: 816.897.0480 E: lovetosmileonsite@gmail.com
www.love-to-smile.com/smileonsite

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 OnSite 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 OnSite 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 OnSite

AUTO CHECK-OUT

Patient Name: _____

Email: _____Phone: _____

Our easy and convenient auto check out gives you one less thing to do. Credit card information will be kept only in our secure patient portal. For any amounts greater than $75 we will contact you for approval. All payment receipts will be immediately emailed to you.

Cardholder Name _____

Cardholder Address _____

_____

Credit Card Number _____

Exp. Date _____ Security Code _____

Cardholder Signature _____

M/C Visa Discover

_____ I elect to have my account set up for automatic check out and request Love To Smile OnSite, LLC to charge the above credit card.

Signature of Patient/Parent or Guardian _____Date: _____

Witness _____ Date: _____

LOVE TO SMILE ONSITE, LLC
10925 Antioch Rd | Overland Park, KS 66210 | 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 OnSite 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 OnSite 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 of 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

LOVE TO SMILE ONSITE, LLC
10925 Antioch Rd | Overland Park, KS 66210 | 913.491.1200

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Love To Smile OnSite, LLC 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 OnSite, LLC 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 OnSite, LLC 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 OnSite, LLC at 10925 Antioch Road | Overland Park, KS 66210.

_____ With this consent, Love To Smile OnSite, LLC may call my home or other alternative location and leave a message on voicemail 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 OnSite, LLC 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 OnSite, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient reminder cards and patient statements. I have the right to request that Love To Smile OnSite, LLC 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 OnSite, LLC 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 OnSite, LLC may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian Relationship to Patient

_____

Print Patient's Name Date

_____

Print Name of Parent or Legal Guardian, if applicable

SYMPTOM EVALUATION QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____

Do you have any of the following symptoms:

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

Other symptom(s): _____

_____

_____

_____

X _____ _____

Signature of Patient or Legal Guardian | Date