DENTAL DESIGNS KC
COSMETIC & FAMILY DENTISTRY

PATIENT INFORMATION

Today's Date : _____

Name (First) _____ (Middle Initial) ____ (Last) _____ (Preferred/Nickname) _____

Address_____

City_____ State_____ Zip_____

Date of Birth_____ SS#_____ Sex M_____ F_____

Married_____ Single_____ Child_____ E-mail address_____

Phone Cell (____) _____ Work (____) _____x____ Home (____) _____

Referred by _____ Employer/Occupation_____

Doctor Preference ____Stephen Russell ____Grant Smith ____No preference

SPOUSE INFORMATION

Name (First) _____ (Middle) _____ (Last) _____

Date of Birth_____ SS#_____ Sex M_____ F_____ Employer _____

Phone Home (____) _____ Work (____) _____x____ Cell (____) _____

PARENT INFORMATION (if patient is child)

Mother____ Father____ Step____ Other_____

Name (First) _____ (Middle) _____ (Last) _____

Address_____

City_____ State_____ Zip_____ Employer _____

Date of Birth_____ SS#_____ Sex M_____ F_____

Phone Home (____) _____ Work (____) _____x____ Cell (____) _____

Mother____ Father____ Step____ Other_____

Name (First) _____ (Middle) _____ (Last) _____

Address_____

City_____ State_____ Zip_____ Employer _____

Date of Birth_____ SS#_____ Sex M_____ F_____

Phone Home (____) _____ Work (____) _____x____ Cell (____) _____

PRIMARY DENTAL INSURANCE

Policy Holder _____ DOB _____

Employer_____ Group #_____

Insurance Company_____

ID# or SSN _____

SECONDARY DENTAL INSURANCE

Policy Holder _____ DOB _____

Employer_____ Group #_____

Insurance Company_____

ID# or SSN _____

DENTAL HISTORY

Reason for today's visit? _____ **Name of Last Dentist?** _____

Last Cleaning?_____ **Last X-rays?** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have read a copy of Dr. Russell and Dr. Smith's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. A copy of the Notice is available upon my request. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice.

SIGNATURE:_____DATE:_____

Print Name: _____ Relationship to Patient: Self Mother Father Other:_____

HEALTH HISTORY (please indicate "yes" or "no")

Y N		Y N		Y N	
○ ○	AIDS/HIV	○ ○	Cortisone/Steroid Treatment	○ ○	High Blood Pressure
○ ○	Anxiety/Nervous Problems	○ ○	Diabetes (circle) type 1/type 2	○ ○	Kidney Disease
○ ○	Asthma	○ ○	Drug/Alcohol Abuse	○ ○	Liver Disease
○ ○	Blood Disorder	○ ○	Emphysema/Respiratory Disease	○ ○	Low Blood Pressure
○ ○	Anemia	○ ○	Epilepsy	○ ○	Migraines/Frequent Headaches
○ ○	Other _____	○ ○	Fainting/Dizziness	○ ○	Premedicate (prior dental procedure)
○ ○	Blood Thinners (i.e.-Coumadin, Warfarin, Aspirin)	○ ○	Fen-Phen (Diet Pills)	○ ○	Psychiatric Care
		○ ○	Heart Problems	○ ○	Rheumatic Fever
○ ○	Bones/Joints	○ ○	Artificial Heart Valves	○ ○	Scarlet Fever
○ ○	Arthritis/Rheumatism	○ ○	Congenital Heart Lesions	○ ○	Skin Rash
○ ○	Artificial Joints	○ ○	Heart Disease	○ ○	Stroke
○ ○	Other _____	○ ○	Heart Murmur	○ ○	Thyroid Problems
○ ○	Cancer (type) _____	○ ○	Mitral Valve Prolapse	○ ○	Tuberculosis
○ ○	Chemotherapy	○ ○	Pacemaker	○ ○	Tumor
○ ○	Radiation Therapy	○ ○	Other _____	○ ○	Weight Loss, unexplained
○ ○	Cold Sores/Fever Blisters/Herpes	○ ○	Hepatitis (type)_____	○ ○	Eating Disorder

Physician's Name _____ Phone (_____) _____

Have you had any recent surgeries/hospitalizations? (past 5 years) _____

ALLERGIES

Y N	
○ ○	Aspirin
○ ○	Barbiturates (Sleeping Pills)
○ ○	Codeine
○ ○	Flavoring Agents (i.e.-Mint/Cinnamon)
○ ○	Iodine
○ ○	Latex
○ ○	Local Anesthetics/Epinephrine
○ ○	Penicillin
○ ○	Sulfa
○ ○	Other _____
	_____

MEDICATIONS

Please list any medications you are currently taking and reason:

_____

_____

_____

Have you ever been told you needed an antibiotic prior to dental treatment? (Circle one) YES NO

Pharmacy Name _____

Phone (_____) _____

WOMEN: Are you pregnant? Y N Due Date?_____
Are you nursing? Y N Taking Birth Control? Y N

Emergency Contact _____
Phone #_____

You agree, in order for us to service your account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lendor/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me/us as described above.

I acknowledge that if I do not give 24 hours notice of cancellation (by phone call) , I am responsible for a $50 cancellation fee (subject to change).

I acknowledge that I (the patient), am responsible to know my insurance benefits, and benefits are not guaranteed until the insurance company has made payment.

I acknowledge that payment is due when services are rendered.

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for this activities and health care operations that are related to treatment.

Patient's / Parent's Signature _____ Date _____