

Welcome

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# _____ Insurance ID # _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City/State/Zip _____
Insurance Company _____ Group # _____ Phone # _____
Ins. Co. Address _____ City/State/Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ? YES ? NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# _____ Insurance ID # _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City/State/Zip _____
Insurance Company _____ Group # _____ Phone # _____
Ins. Co. Address _____ City/State/Zip _____

We will accept assignment of benefits and file your dental claim for you. We do require insurance co-payments and deductibles to be paid at the time of service. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not part of the contract. Any patient receiving treatment is responsible for full payment.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient (or parent/guardian if minor)

PATIENT INFORMATION

Patient's Name _____ Today's Date _____
Home Address _____
City/State _____ Zip _____ Tel. # _____
Social Security # _____ - _____ - _____ Date of Birth _____ Age _____ Martial Status S/M/D/W
Cell Phone # _____ Email Address _____
Your Occupation _____ Employer _____ Work # _____
Spouse's Name _____ Social Security # _____ - _____ - _____ Date of Birth _____
Your Spouse's Occupation _____ Employer _____
Person to Contact in an emergency _____ Relation _____
Telephone # _____ Address _____
Party responsible for Account _____ Work # _____ Home # _____
Whom may we thank for referring you? _____

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL.

Dental History:

Previous Dentist _____ City/State _____ How Long _____
Date of last visit _____ Date of last dental cleaning _____ Date of last full mouth x-ray _____
Why did you leave your last dentist? _____
What did you like most about any dentist, or a dental office, you have been to? _____
What did you like least about any dentist, or a dental office, you have been to? _____
Reason for this visit _____

Check any of the following you have had or currently have:

- | | |
|--|---|
| <input type="checkbox"/> Mouth Discomfort | <input type="checkbox"/> Loose or Shifting Teeth |
| <input type="checkbox"/> Have Lightened Your Teeth Before | <input type="checkbox"/> Trouble Chewing/Speaking |
| <input type="checkbox"/> Grind or clench your teeth (Daytime or Nighttime) | <input type="checkbox"/> Fear of Dental Treatment |
| <input type="checkbox"/> Pain, Clicking, Popping in Jaw Joints | <input type="checkbox"/> Immediate Relatives that have lost all their Natural Teeth |
| <input type="checkbox"/> Awake with Sore Jaws | <input type="checkbox"/> Orthodontic Treatment |
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitive Teeth (Hot, Cold, Sweets) |
| <input type="checkbox"/> Gum Abscesses | <input type="checkbox"/> Complications with or following previous Dental or Oral Surgical Treatment |
| <input type="checkbox"/> Gums Bleed when Brushing | <input type="checkbox"/> Cold Sores or Fever Blister |
| <input type="checkbox"/> Mouth Odor or Bad Taste | <input type="checkbox"/> Cavities |
| <input type="checkbox"/> Bruise Easily | |
| <input type="checkbox"/> Painful Teeth | |

If you could change one thing about your smile, what would that be? _____
If there was a simple way to whiten your teeth, would you be interested? Y N

Financial Policy
Acknowledgement of Privacy Practices

Dental Corner
2046 North Oliver
Wichita, KS 67208

(316) 681-2425

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy. We require that you read and sign this prior to any treatment.

Full payment is due at the time of service. Treatment Estimates are only estimates. We are committed to your estimate being as accurate as possible; however, sometimes it is necessary for the estimate to change during the course of treatment. Should your account balance exceed 30 days, an annual percentage rate of 18% will be applied.

I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated fees are my responsibility.

We accept cash, checks, debit card, Visa, MasterCard, Discover and American Express.

Regarding Insurance

We will accept assignment of insurance benefits and file your dental claim for you. We do require insurance co-payments and deductibles to be paid at the time of service. The balance is your responsibility whether your insurance pays or not. Should your account balance exceed 30 days, an annual percentage rate of 18% will be applied. Your insurance policy is a contract between you and your insurance company. We are not part of that contract. Any patient receiving treatment during hours that insurance can't be verified is responsible for full payment.

Failed Appointments

There will be a \$35.00 charge for failed appointments. If you need to reschedule an appointment, we require 24 hours notice. If you fail three appointments, we reserve the right to dismiss you as a patient.

Notice of Privacy Practice Patient Acknowledgement

I have received and understand this practice's Notice of Privacy written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the financial policy above. I understand and agree to this financial policy.

I have read and understand the Notice of Privacy Practice.

I have read and understand the Notice of Privacy Practice patient acknowledgment.

Signature

Date

Responsible Party Signature (if signed by a personal representative of patient)

Date