

Last Name _____ First Name _____ Middle Initial _____

Salutation: Mr. Mrs. Ms. Dr. Other: _____

What do you like to be called? _____

Date of Birth _____ Social Security Number _____

Sex _____ Marital Status: Single Married Partnered Widowed Divorced

Home Address _____ City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Cell Phone _____ E-mail Address _____

How would you prefer to be contacted? Home Telephone Work Telephone Cell Phone Text Message E-mail

Occupation _____ Employer _____

Student? No Yes (Full-time Part-time) Name of School _____

What is your preferred appointment day and time? _____

Emergency Contact _____ Phone _____

How did you hear about us? _____

Do we treat any other members of your family? _____

Are there any members you prefer to have listed on a separate account? Yes No List _____

The purpose of my visit is _____

If you have dental benefits, please provide the following information:

Employer _____ Address _____

Insurance Company _____ Address _____

Policy Number _____ Group Number _____ ID Number of Insured _____

If you have dental benefits through a family member, please provide the following information:

Name of Insured: Last _____ First _____ Middle Initial _____

Insured Date of Birth _____ Relationship to Insured _____ SS Number of Insured _____

Policy Number _____ Group Number _____ ID Number of Insured _____

Employer _____ Address _____

Insurance Company _____ Address _____

If patient is a minor or someone other than the patient is responsible for the account, please provide the following information:

If Dependant Child: Father's Date of Birth _____ Mother's Date of Birth _____

Name of Responsible Party _____ Relationship _____ Telephone _____

Street Address _____ City _____ State _____ Zip _____

Signature of Guardian (for patients under 18) _____ Date _____

To the best of my knowledge, the questions on this form have been accurately answered.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

At Hesston Dentistry, we realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of options to help you receive the dental care you need and deserve; care that allows you to enjoy a healthy, beautiful smile with respect to your budget.

Hesston Dentistry accepts cash, personal checks and most major credit cards. In addition, we offer excellent financial payment plans for treatment plans over \$500. Our office staff would be happy to provide you with more detailed information on these plans if you are interested.

If you have dental insurance, you must bring proof of insurance and we will be more than happy to submit your insurance claims for you. However, you must realize:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a part of that contract.
2. We cannot render services on the assumption the charges will be paid for by an insurance company. All charges are your responsibility from the dates the services are rendered.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.
4. You must update our office staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.

You may direct the insurance company to pay their share of the cost directly to our office. Often, we do not receive these insurance payments until two to four months after being submitted for payment; therefore, we do ask that you pay your estimated share at the time treatment is rendered. Upon receipt of the insurance payment, we will reconcile your account and bill or refund any difference.

We must emphasize that as dental care providers, our relationship is with you, the patient, not your insurance company. While filing insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payments of your account and if such situations do arise, we encourage you to contact us promptly for assistance and management of your account.

Outstanding balances older than 60 days will be subject to finance charges at the rate of 1.5% monthly. Returned checks will be subject to a \$30 returned check fee.

If you have any questions about the above information, please do not hesitate to ask. We are here to serve you.

I understand and accept the terms outlined in this financial agreement. If I have dental insurance, I agree to be responsible for all charges for dental services not paid by my dental benefit plan, unless Hesston Dentistry has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to insurance claims and authorize payment of dental benefits otherwise payable to me directly to Hesston Dentistry.

Patient or Guardian Signature

Date

MEDICAL HISTORY

Patient Name _____

Date of Birth _____

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.

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

If yes to any of these, please explain: _____

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 Local Anesthetics
- Other _____

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

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Aids / HIV Positive | <input type="checkbox"/> Cold Sores / Fever Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attack / Failure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Stomach / Intestinal Disease |
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Trouble / Disease | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tired |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Fainting Spells / Dizziness | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Tumor or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Shingles | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sinus Trouble | |

Have you ever had any serious illness that are not listed above? Yes No If yes, please explain: _____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature _____ Date _____
 Parent or Guardian Signature _____ Date _____

Patient Name _____ How often do you brush your teeth? _____

Date of Birth _____ How often do you floss? _____

What is the reason for your visit today? _____ What other dental aids do you use (interplak, toothpick, etc.)? _____

_____ Do you have any dental problems now? Yes No

Date of Last Dental Visit _____ If yes, please describe: _____

Date of Last Dental Cleaning _____

Date of Last Full Mouth X-rays _____ How often do you have dental examinations? _____

Are any of your teeth sensitive to:

- Hot or cold? Yes No
- Sweet or sour liquids? Yes No
- Biting or chewing? Yes No
- Have you ever noticed any mouth odors or bad tastes? Yes No
- Do you frequently get cold sores, blisters, lumps or any other oral lesions? Yes No

Do you:

- Have gums that bleed or hurt? Yes No
- Have your parents experienced gum disease or tooth loss? Yes No
- Have you noticed any loose teeth or change in your bite? Yes No
- Does food tend to become caught in between your teeth? Yes No
- If yes, where? _____

Do you:

- Clench or grind your teeth while awake or asleep? Yes No
- Bite your lips or cheeks regularly? Yes No
- Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? Yes No
- Mouth breathe while awake or asleep? Yes No
- Have tired jaws, especially in the morning? Yes No

Have you ever had:

- Orthodontic treatment? Yes No
- Oral surgery? Yes No
- Difficult extraction? Yes No
- Periodontal treatment? Yes No
- Prolonged bleeding following extractions? Yes No
- Your teeth ground or the bite adjusted? Yes No
- A bite plate or mouthguard? Yes No
- A serious injury to the mouth or head? Yes No
- If so, please describe, including cause: _____

Have you experienced:

- Clicking or popping of the jaw? Yes No
- Pain (joint, ear, side of face, teeth)? Yes No
- Difficulty in opening or closing the mouth? Yes No
- Difficulty in chewing on either side of the mouth? Yes No
- Headaches, neck aches or shoulder aches? Yes No
- Sore muscles (neck, shoulders)? Yes No
- Have you ever had instruction on the correct method of brushing your teeth? Yes No
- Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe: _____

Cosmetics:

- Do you like the appearance of your teeth and your smile? Yes No
- Are your teeth all in alignment (straight)? Yes No
- Do you have spaces you don't like? Yes No
- Do you like the color of your teeth? Yes No
- Do you like the shape of your teeth? Yes No
- Are your teeth: chipped? protruding? hidden?
- Have you used any tooth whitening products? Yes No
- Do you like the way your teeth come together? Yes No
- Are there old silver fillings or dental treatment that you don't like the appearance of? Yes No
- What would you like to change most in the appearance of your teeth?

How would you like your teeth to look? _____

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.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/09, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTH CARE OPERATIONS: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that may do so.

PERSONS INVOLVED IN CARE: We may use and disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security advances. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards or letters).

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$.75 for each page, \$10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.) **Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6 years, but not before January 1, 2009. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation to how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Justin Dillner | Telephone: 620-327-2887 | Fax: 620-327-2078 | Address: 353 N. Old Highway 81 , P.O. Box 250, Hesston, KS 67062

Signature _____ Office Representative _____