Cosmetic & Implant Dentistry of Kansas City

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Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Please enter Employer and Occupation

Whom may we thank for referring you to our practice?

Insurance Authorization:

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact: *

Responsible Party Information:

This ONLY needs to be completed if the patient is under 18 years.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Smile Club

Professional basic dental cleaning (2 per 12-month period)
Doctor periodic exams (2 per 12-month period)
Emergency exam (1 per 12-month period)
Necessary x-rays
20% discount on other treatments by General Dentists and 10% by Specialists and in conjunction with Care Credit or Lending Club (some exclusions may apply)
Free Electric Toothbrush
$399 annual fee (children 14 and under $349 includes fluoride vanish)

◯ Yes ◯ No

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Company Phone Number:

_____

_____

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Financial Policy

How would you like to be contacted regarding any balance due on your account? Please understand that any balance on your account is due within 10 days. *

☐ Credit Card on File ☐ Email ☐ US Mail ☐ Text Message ☐ Phone Call

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about fees, financial policy or your responsibility.

1. Payment is due at time of service and a deposit of $45 per hour of appointed time is required for reserving an appointment. This deposit may be forfeited if proper notice (48 hours) is not given to reschedule/cancel an appointment. A credit card can be kept on file to pay your portion of services if another form of payment is not presented.
2. If insurance is involved, co-payment and any deductible are to be paid at the time services are rendered. Your deposit will be credited toward your services if your reserved time is in good standing.
3. We accept cash, check, MasterCard, VISA, Discover and American Express.

Dental insurance should be regarded as dental assistance. It is designed to help pay some of the costs of dental treatment. Because there are so many dental insurance companies and programs it is nearly impossible for us to have complete knowledge about all of them, or your status with your particular company. We will do our best to help you maximize your benefits. Dental insurance is meant to be a partial aid to defray professional fees. It is not designed to pay all the costs of dental treatment. Insurance is a contract between you and your insurance company. We are typically not a party to this contract. If we are, we will inform you and handle the claim according to our agreement with the insurance company. We file insurance as a courtesy to our patients. We will not become involved in disputes between you and your insurance regarding deductibles, co-payments, covered charges, secondary insurance and other matters regarding reimbursement.

The kind of benefits in your contract depend on what you or your employer have negotiated with the insurance carrier, and the amount of money you choose to pay in premiums. Returned checks will receive a $25.00 overdraft charge. At the time of your initial appointment, please bring your insurance card and photo identification and a credit card to be kept on file. Your portion of the fees less your deposit if the reserved time is kept in good standing can then be computed and paid at the completion of your appointment. If the insurance payment varies from the computed amount, an adjustment will be made. If care is being rendered on a minor child, the parent or guardian who accompanies the child to the appointment is financially responsible for the account. You are responsible for timely payment of your account. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I understand that I am responsible for all costs of dental treatment regardless of what my insurance carrier may or may not pay. This signature will also serve as signature on file for assignment of insurance benefits. In the event of any default regarding charges incurred, the debtor will be obligated to pay all collection costs &/or attorney fees incurred by Cosmetic and Implant Dentistry of Kansas City in the collection of these charges.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm. I grant permission to you or your assignee, to telephone me to discuss this statement or my treatment.**

Potential Risks and Limitations of Dental Treatment

As a rule, excellent dental results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering dental treatment in our office. While recognizing the benefits of a pleasing smile and healthy teeth, you should be aware that dental treatment, like any treatment of the body has some inherent risks and limitations. These risks and limitations do not contra-indicate treatment, but should be considered in making the decision to submit to dental treatment. Perfection is our goal. However, in dealing with human beings and problems of growth and development, the ravages of dental disease, genetics and patient cooperation, achieving perfection is not always possible. Often a functionally and esthetically adequate result must be accepted. You will be treated by a licensed dentist who will do everything within his/her capacity to insure the best results. Throughout life, teeth are constantly changing. Periodic examinations should be made so any disease can be treated properly. Frequent professional visits are the best insurance against serious dental disease. Decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and plaque removal is a must. On rare occasions, the nerve of the tooth may die and become infected. A tooth that has been damaged by deep decay, a minor blow or extensive dental treatment can die over a long period of time. An undetected non-vital tooth may flare-up during dental treatment and may require endodontic (root canal) treatment to maintain it. The tooth may even have to be removed. There is also a risk that during or following treatment soreness or tenderness may occur in the temporomandibular joints (lower jaw joints).

Informed Consent

I understand that during dental treatment occasionally any of the above problems may occur. These can include but are not necessarily limited to: pain (discomfort), tooth mobility, tooth decay, devitalization (nerve loss), tooth and/or jaw changes, and injury resulting from the use of high speed dental equipment. I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that for a successful result and to lessen the dangers of complications, the following conditions are essential on my part:

1. Excellent oral hygiene
2. Proper diet controls
3. Strict adherence to instructions
4. Cooperation in keeping dental appointments. If an appointment is not cancelled at least 48 hours in advance, you will be charged a $50 fee; this will not be covered by your insurance company.

I understand that there is no warranty to my result and/or care. I also understand that I can, at any time, ask for and receive a full recital of all possible risks related to my treatment. In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification; who are constantly late for their appointments; who continue to excessively cancel their appointments; who fail to practice acceptable oral hygiene; or who are uncooperative with the dentists and staff providing care.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

(Please enter name and relationship to patient.)

_____

_____

I authorize this office to leave a detailed voicemail (including account, treatment and financial information). * ◯ Yes ◯ No

Please provide phone number you would like voicemail (if different than provided): _____

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Photo Release

Cosmetic and Implant Dentistry of Kansas City has permission to use my likeness in a photograph in any and all of its educational publications including but not limited to printed and digital publications. *

◯ Yes ◯ No

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

Name of person filling out this form: *

_____

_____

Relationship to patient: *

☐ Self ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Legal Guardian ☐ Other

Response Date: _____