PATIENT REGISTRATION

First Name:_____ Last Name:_____ Middle Initial:_____

Patient is: __ Policy Holder __ Responsible Party Preferred Name:_____

Responsible Party (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____ Address 2:_____

City:_____ State/Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth Date:_____ Soc Sec:_____ Drivers License:_____

E-Mail:_____

__ Responsible Party is also a Policy Holder for Patient __Primary Insurance Policy Holder __Secondary Insurance Policy Holder

Patient Information

Address:_____ Address 2:_____

City:_____ State/Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Sex: __ Male __ Female Marital Status: __Married __Single __Divorced __Widowed

Birth Date:_____ Age:_____ SSN: _____ Drivers License: _____

E-Mail:_____

Primary Insurance Information

Name of Insured:_____ Relationship to Insured: __ Self __ Spouse __ Child

Insured SSN:_____ Insured Member Id:_____ Insured Date of Birth:_____

Employer:_____ Ins. Company:_____ Group No.:_____

Address:_____ Address:_____

Address 2:_____ Address 2: _____

City, State, Zip:_____ City, State, Zip:_____

Secondary Insurance Information

Name of Insured:_____ Relationship to Insured: __ Self __ Spouse __ Child

Insured SSN:_____ Insured Member Id:_____ Insured Date of Birth:_____

Employer:_____ Ins. Company:_____ Group No.:_____

Address:_____ Address:_____

Address 2:_____ Address 2: _____

City, State, Zip:_____ City, State, Zip:_____

Financial Policy

Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan, financial responsibility, and our financial policy.

Financial Agreement

Patients are expected to pay for their services at the time they are rendered. Our patients with dental insurance are expected to pay their estimated co-pay and deductible at the time of service. Your insurance policy is an agreement between you and your insurance carrier; therefore, all patients are directly responsible for all charges. Once your insurance carrier has made a determination, you will be responsible for any balance due upon receipt of our statement, whether insurance has paid or not. Payment may be made using: Cash, Check, Visa, MasterCard, American Express or Discover. We also accept CareCredit.

Children of Divorced/Separated Parents

Unless you give us a signed, notarized court order to keep on file, the parent who brings the child in for their care will be considered the responsible financial party/parent. For any remaining balances after insurance has paid the bill will be mailed to the responsible party/parent on the account.

Appointments

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases when people fail to keep scheduled appointments or cancel at the last minute. We request at least a 24-hour notice for any cancelled or rescheduled appointments or there may be a $25 fee assessed. After 3 missed or last-minute cancelled appointments you may be placed on a short call list, which means we will contact you when an appointment time becomes available on short notice. This gives you the opportunity to know if your schedule is open for an appointment.

Insurance

I, the undersigned certify that I (or my dependents) have insurance coverage with _____ and assign payment directly to the doctor for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I agree to the terms as listed above:

Patient/Responsible Party Date

Gilroy Dental Care

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 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? __yes __ no If yes_____

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

AIDS/HIV positive	__Y __N	Cortisone Medicine	__Y __N	Hemophilia	__Y __N	Radiation Treatments	__Y __N
Alzheimer's Disease	__Y __N	Diabetes	__Y __N	Hepatitis A	__Y __N	Recent Weight Loss	__Y __N
Anaphylaxis	__Y __N	Drug Addiction	__Y__N	Hepatitis B or C	__Y __N	Renal Dialysis	__Y __N
Anemia	__Y __N	Easily Winded	__Y __N	Herpes	__Y __N	Rheumatic Fever	__Y __N
Angina	__Y __N	Emphysema	__Y __N	High Blood Pressure	__Y __N	Rheumatism	__Y __N
Arthritis/Gout	__Y __N	Epilepsy or Seizures	__Y __N	High Cholesterol	__Y __N	Scarlet Fever	__Y __N
Artificial Heart Valve	__Y __N	Excessive Bleeding	__Y __N	Hives or Rash	__Y __N	Shingles	__Y __N
Artificial Joint	__Y __N	Excessive Thirst	__Y __N	Hypoglycemia	__Y __N	Sickle Cell Disease	__Y __N
Asthma	__Y __N	Fainting Spells/Dizziness	__Y__N	Irregular Heartbeat	__Y __N	Sinus Trouble	__Y __N
Blood Disease	__Y __N	Frequent Cough	__Y __N	Kidney Problems	__Y __N	Spina Bifida	__Y __N
Blood Transfusion	__Y __N	Frequent Diarrhea	__Y __N	Leukemia	__Y __N	Stomach/Intest Disease	__Y __N
Breathing Problems	__Y __N	Frequent Headaches	__Y __N	Liver Disease	__Y __N	Stroke	__Y __N
Bruise Easily	__Y __N	Genital Herpes	__Y __N	Low Blood Pressure	__Y __N	Swelling of Limbs	__Y __N
Cancer	__Y __N	Glaucoma	__Y __N	Lung Disease	__Y __N	Thyroid Disease	__Y __N
Chemotherapy	__Y __N	Hay Fever	__Y __N	Mitral Valve Prolapse	__Y __N	Tonsillitis	__Y __N
Chest Pains	__Y __N	Heart Attack/Failure	__Y__N	Osteoporosis	__Y __N	Tuberculosis	__Y __N
Cold Sores/Fever Blisters	__Y__N	Heart Murmur	__Y __N	Pain in Jaw Joints	__Y __N	Tumors or Growths	__Y __N
Congenital Heart Disorder	__Y __N	Heart Pacemaker	__Y __N	Parathyroid Disease	__Y __N	Ulcers	__Y __N
Convulsions	__Y __N	Heart Trouble/Disease	__Y__N	Psychiatric Care	__Y __N	Venereal Disease	__Y __N
						Yellow Jaundice	__Y __N

Have you ever had any serious illness not listed above? __Yes __No If Yes _____

Additional 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 _____

Relationship to patient: _____

Dental History Questionnaire

Name (Last, First, M.I.) **__M __F DOB:**

Please answer the questions below. Check all that apply.

Visit History:

How often do you visit the dentist? __Never/First Visit __1-2 per year __More than twice a year __Irregular __Emergencies
What was done at your last dental visit (reason for last dental visit)?_____
What is the reason for your visit today?_____
Do you need treatment every time you visit the dentist? __ Yes __ Sometimes, but not always __ Never
When is the last time you had a dental cleaning? __ 6 months ago __ 1-2 years ago __ over 2 years __ Never

Current Problem:

Are you in any discomfort at this time? __ Yes __ No
Rate your discomfort from 1 (mild) to 10 (very painful) _____
How long has this condition been bothering you?_____
How can we address this problem for you today?_____

Smile Cosmetic:

What 3 things would you change about your Smile or Teeth?_____
Of those 3 things which is the most important to you?_____
What are the cosmetic procedures in which you are interested?_____

Past Experience:

Do you have a fear of the dentist or dental work? __ Yes __ No
What specifically do you dislike or fear the most?_____
Are there any problems with you past dental experiences that you would like to avoid? __ Yes __ No
Please Explain if you answered yes: _____

General History:

Would you like to replace your missing teeth? _____
Any past complications with dental work? __ Yes __ No Why?_____
Have you ever had your teeth straightened (orthodontics)? __ Yes __ No
Are your teeth sensitive to (check all applicable): __ Heat __ Cold __ Sweets __ Air
Do you feel you have bad breath at times? __ Yes __ No
Do your gums Bleed when you brush? __ Yes __ No How often do you brush your teeth? _____
Have you ever had Gum treatments? __ Yes __ No
Does food wedge between your teeth? __ Yes __ No Where? _____

TMJ / JAWS:

Do you grind or clench your teeth? __ Yes __ No Do you have pain in your Jaw joints? __ Yes __ No
Does your Jaws Pop or click? __ Yes __ No What side? __ Right __ Left
Do you feel you have broken or chipped teeth without reason? __ Yes __ No
Does your bite feel "off " sometimes or all of the time? __ Yes __ No
Do you wear a night guard? __ Yes __ No Do you get frequent headaches? __ Yes __ No
Has your Jaw ever locked open or closed? __ Yes __ No Which? _____

My mouth is: __ Very Comfortable __ Moderately Comfortable __ Uncomfortable
The appearance of my smile is: __ Excellent __ Satisfactory __ Needs Improvement __ Very unsatisfactory

__ I will do anything to keep my teeth healthy and looking great
__ I want a healthy mouth and teeth, but only what is covered by insurance
__ I just don't want my teeth to hurt, I don't care about health

__ I have set goals for my oral health with my previous dentist
__ I want to set goals for my dental health
__ I have never thought about goals for my dental health

On a scale of 1 to 10 below, rate where your present dental health is:

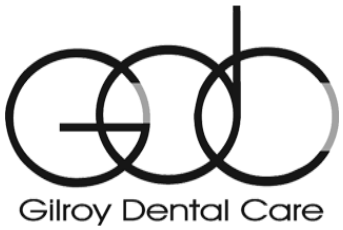
1_____10
Very Poor Excellent

Rate where you would like your dental health to be in 5 years.

1_____10
Very Poor Excellent

What are some additional questions about your dental health that you would like answered?

_____
_____



Consent

Patient Name: _____ Date of Birth: _____

I give consent for myself/my dependent to receive dental treatment deemed necessary by the providers at Gilroy Dental Care. These procedures include, but are not limited to: Examinations, radiographs, study models, photographs, oral prophylaxis (cleaning), fluoride treatments, sealants, restorations (composite fillings, (amalgam: silver filling by request only) and crowns), periodontal treatment (gum disease), endodontic treatment (root canal), extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling bruising, allergic reactions, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

Print Name Relationship if for Dependent Date

Your signature Date

HIPAA

Acknowledgement of Receipt

I acknowledge that I received a copy of Gilroy Dental Care's notice of Privacy Practice.

Patient Name: _____

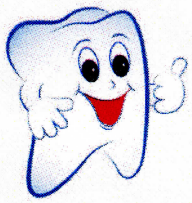
Patient or Guardian's Signature: _____ Date: _____

Relationship if Guardian: _____

Authorization to share my information with the following person(s):

_____ Relationship: _____

_____ Relationship: _____



Gilroy Dental Care

11826 W. 135th St
Overland Park, KS 66221
913-681-1900

RECORD RELEASE FORM

I, _____ request the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to Gilroy Dental Care:

Email: gilroydentalcare@gmail.com

Name of Patient:_____ Date of Birth: _____

Name of Patient:_____ Date of Birth: _____

Name of Patient:_____ Date of Birth: _____

Records being requested:

( ) Current radiographs

( ) Other: _____

_____

Signature of Parent/Guardian: _____ Date: _____