

PATIENT INFORMATION

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M.I.
SOCIAL SECURITY # _____ AGE _____
ADDRESS _____
STREET APT. # CITY STATE ZIP
BIRTHDATE _____ TELEPHONE _____
MM/DD/YYYY HOME WORK CELL E-MAIL
NAME OF EMPLOYER _____ ADDRESS _____
IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____
PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED

IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M.I.
STREET CITY STATE ZIP
HOME WORK CELL E-MAIL
BIRTHDATE (MM/DD/YYYY) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INSURANCE CO.
SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M.I.
STREET CITY STATE ZIP
HOME WORK CELL E-MAIL
BIRTHDATE (MM/DD/YYYY) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INSURANCE CO.
SS# SUBSCRIBER # GROUP #

Whom may we thank for referring you to our office?

Friend or Relative _____ Direct Mailer Yellow Pages Drive-By Other _____

EMERGENCY CONTACT

NAME _____
ADDRESS _____
CITY/STATE/ZIP _____
TELEPHONE # _____
RELATIONSHIP TO PATIENT _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party
Date State Driver's License #

METHOD OF PAYMENT

Responsible party currently has an account with our office:

YES NO

Payment in full at each appointment (cash or personal check)

Payment in full at each appointment (VISA MC OTHER)

Card # _____ Exp. Date _____

I wish to discuss the Dental Office's Financial Policy.

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of \$_____ for a balance under \$_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due. Together with any collection costs and reasonable attorney fees incurred to effect collection of this account for future outstanding accounts.

APPOINTMENT POLICY

Broken appointments inconvenience many people. If unable to keep an appointment please give us at least 48 hours notification so we can make that time available to someone else. Thank you.

X _____
Patient or Responsible Party Date

PATIENT NAME _____ DATE _____

Dental History

What is the primary reason for your visit today? _____
 How long has it been since your last dental visit? _____ Last X-Rays? _____
 Why did you leave your last dentist? _____
 How do you feel about the appearance of your smile? _____
 Would you like your teeth whiter? _____
 Is there something about your teeth you do not like? _____
 Do you notice if you have bad breath? _____
 Is there anything else about your teeth that concerns you? _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
 Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
 Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
 Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
 Are you on a special diet? Discuss _____ Yes No
 Are you allergic to any medications or substances? Please check box below _____ Yes No
 Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk Other _____
 Women (Please Check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss _____ Yes No

Do you now or have you ever had any of the following? Do you take any of these medicines? Please check the appropriate boxes.
***If yes to any of the starred conditions, please call prior to your appointment...premedication or changes in medication may be required.**

	YES	NO		YES	NO		YES	NO		YES	NO			
Heart Disease/Surgery*	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur or Defect*	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Bisphosphonates	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Methemoglobinemia	<input type="checkbox"/>	<input type="checkbox"/>	Osteonecrosis of Jaw	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Aredia I.V. Reclase I.V.	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder*	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Zometa I.V.	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Fosamax, Actonel, Boniva	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker*	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint*	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Shunt*	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Medicines)	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Pollen/Dust)	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial Endocarditis*	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained Fever	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction/Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Need Premedication?	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily/Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Tattoos/Body Piercing	<input type="checkbox"/>	<input type="checkbox"/>	Ever taken fen-phen?*	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Protese Inhibitor	<input type="checkbox"/>	<input type="checkbox"/>				Cochlear Implants?	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Stent*	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Treatments (Radiation)	<input type="checkbox"/>	<input type="checkbox"/>									

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
 Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____
 History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Dental Care Center of South Kansas City
Gregory A. Stiver, D.D.S.
13643-A Holmes Road
Kansas City, MO 64145
(816) 941-7788

I understand that, that under the Health Insurance Portability & Accounting Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used, but not mandatory for me to sign in order to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by this office of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of this office's Privacy Practices prior to signing this consent. I understand that this organization has the right to change it's Privacy Practices from time to time and that I may contact this organization at anytime at the above address to obtain a current copy.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that this organization is not required to agree to my requested restrictions, but if this organization does agree, then this organization is bound to abide by such restrictions.

I, the undersigned hereby understand that I may revoke this consent in writing at anytime, except to the extent that this organization have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Dental Care Center of South Kansas City
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We thank you for selecting us for your dental care team. We strive to make your relationship with our office a pleasant one. We believe that service to you is at its best when there is complete understanding and mutual cooperation.

We have established the following guidelines to help achieve these goals:

Co-Insurance is due at the time of service.

We have several payment options. We accept Visa, Mastercard, Discover and American Express. Financing through Care Credit or Capital One is also available. Please ask for details.

Although we do our utmost to assist you in obtaining benefits allowable under your dental plan; you should be aware that your insurance is an agreement between you and your insurance company. We cannot be responsible for limitations set by your insurance carrier; therefore, it is your responsibility to pay the balance not paid by your insurance carrier.

It has always been our contention that your time is valuable. We have one theory about scheduling--you deserve our undivided attention. For this reason, we do not double book like other practices, and accept drop-ins **only** in the event of an emergency. For that reason, **there is a \$12.00 missed appointment fee for every 10 minutes scheduled and missed without adequate cancellation notice of at least 48 hours.**

A misunderstanding can be an obstacle to form a satisfactory relationship. If at any time you have a question please feel free to discuss it with us. We would greatly appreciate this.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE:

Patient, Parent or Legal Guardian

Date

Gregory A. Stiver, D.D.S
13643-A Holmes Rd.
Kansas City, Mo. 64145
816-941-7788

Dental Care Center of Kansas City
LIMITED DENTAL WARRANTY

Our practice is proud of the dentistry that we provide for you and your family. Our goal is to not just correct and dental problems you may have, but to show you how to prevent dental disease in the future to save you time and unnecessary expenses. The long term success of the dental treatment we provide for you depends upon your continuing home care of your teeth and gums, regular professional exams, cleanings and fluoride treatments. The products recommended by us for you and the frequency of those professional recare visits depends on your individual condition-and is professionally diagnosed. Those visits may be every 2, 3, 4 or even 6 months apart depending on your oral health. With that in mind we offer the following limited dental warranties:

DENTAL SEALANTS

Sealants are plastic coatings placed on the chewing surfaces of the teeth to prevent decay in the pits and grooves of the teeth. These are the most common areas to get cavities. Floss and the use of fluoride will help prevent decay between teeth. We will repair or replace sealants for a period of 1 year after placement. If decay is present on the chewing surface, the replacement filling will be done at no charge. **You must keep the prescribed regular recall appointments or this warranty is null and void (minimum every 6 months).**

COMPOSITE (tooth colored) FILLINGS

If a composite restoration is the recommended treatment of choice, we will replace or repair it in the event of failure for a period of 1 year. If the tooth breaks and requires a crown we will credit the cost of the filling towards the crown or onlay. **You must keep the prescribed regular recall appointments or the warranty is null and void (minimum every 6 months).**

ROOT CANALS

Root canal treatment is about 96% successful. They do occasionally fail. If you lose your tooth within 1 year due to failure of the root canal, we will refund the root canal fee, or apply a credit towards a replacement tooth. **You must keep the prescribed regular recall appointments or the warranty is null and void (minimum every 6 months).**

CROWNS, BRIDGES AND PORCELAIN VENEERS

We will warranty these most comprehensive procedures for a full 3 years. We will replace or repair them at no charge during this 3 year period if they break or decay with normal use. (This does not include accidents that could also break normal healthy teeth.) **You must keep the prescribed regular recall appointments or this warranty is null and void (minimum every 6 months).**

NOTE: As you can see, we are confident of the durability of our treatment as prescribed for you. The primary key to your long term success is spending a few minutes a day on your home care: brushing, flossing, using fluoride and prescribed products. The second key success is regular professional examinations, cleanings X-ray films and fluoride treatments (2, 3, 4 & 6 month interval as diagnosed by our dentists and your condition.) This warranty does not cover accidents that cause damage to the teeth or dental prosthesis. **FAILURE TO HAVE THESE REGULAR CLEANING & X-RAY VISITS WITH OUR OFFICE AS DIAGNOSED VOIDS ALL WARRANTIES.** Help us to help you maintain your teeth for a lifetime.

Patient Name: _____

Date: _____

Patient Signature

Assistant Signature

Gregory A. Stiver, D.D.S.
Dental Care Center of South Kansas City
13643-A Holmes Road
Kansas City, Mo. 64145
816-941-7788

Patient Consent to leave Detailed Message/ Information

Dear Patient:

Gregory A. Stiver, D.D.S., PC., has adopted a policy that requires our staff to obtain authorization from the patient to leave detailed messages for the patient. This policy is to protect the patient and to protect our office staff from violating the patient's confidentiality. If we do not have a signed consent on file, the staff may only leave their name and a phone number on an answering machine asking you to call them back.

By signing the consent below, you hereby authorize the staff to call and leave their name, doctor's name, and additional information on an answering machine or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give my consent to Gregory A. Stiver and/ or his staff, to leave a message regarding treatment, appointments, or other information as necessary.

Patient Signature

Date

Patient Refusal of Consent to Leave Message/ Information

I refuse to give consent as stated above and, therefore, accept full responsibility to call my physician or his staff on a timely basis to receive results of any tests and/ or exams that were preformed. I understand that if the physician or office staff does call, they will leave a first name only and a request that I return the call, placing the responsibility for the outcome of my medical care fully upon me.

Patient Signature

Date
