Patient Registration

Patient First Name: _____ MI_____ Patient Last Name:_____

Patient Address:_____ City:_____ State:_____ Zip:_____

Primary Contact Number: _____ Alternative Contact Number:; _____

Patient DOB: _____ Soc. Sec. # _____ Sex: Male ☐ Female ☐

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐

Email: _____

Emergency Contact Person and Number: _____ Relationship _____

Is the Patient the Insurance Policy Holder? Yes ☐ No ☐ **If not please complete the following section.**

Primary Insurance Policy Holder:

Policy Holder First Name:_____ Policy Holder Last Name:_____

Policy Holder Address: _____ City:_____ State:_____ Zip: _____

Policy Holder Phone Number: _____Policy Holder DOB: _____

Policy Holder Soc. Sec. # _____

Secondary Insurance Policy Holder:

Policy Holder First Name: _____ Policy Holder Last Name: _____

Policy Holder Address: _____ City: _____ State: _____ Zip: _____

Policy Holder Phone Number: _____ Policy Holder DOB: _____

Policy Holder Soc. Sec. #: _____

Primary Insurance Information:

Insurance Company Name: _____ Employer Name: _____

Employer Address: _____ City:_____ State:_____ Zip: _____

Secondary Insurance Information:

Insurance Company Name: _____ Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Health History Update

Today's Date: _____

Patient's Name:_____ **D.O.B:_____**

Primary Care Physician:_____ **Phone # _____**

Are you currently under medical care? Yes ☐ No ☐

Have you ever had any serious illness or operation? Yes ☐ No ☐ Describe:_____

Do you smoke? Yes ☐ No ☐ Do you use chewing tobacco? Yes ☐ No ☐

Do you take a routine antibiotic before dental appointments? Yes ☐ No ☐

Have you ever had an allergic reaction to:

Local anesthetics? Yes ☐ No ☐ Penicillin or any other antibiotic? Yes ☐ No ☐

Sulfa drugs? Yes ☐ No ☐ Sedatives? Yes ☐ No ☐ Iodine? Yes ☐ No ☐

Aspirin? Yes ☐ No ☐ Other (not listed)? _____

Women Only!

Pregnant? Yes ☐ No ☐ How many weeks?_____ Nursing? Yes ☐ No ☐

Taking contraceptive pills? Yes ☐ No ☐ Are you currently or have you ever under went treatment for Osteoporosis? Yes ☐ ☐

Please list below any medications you are taking including any over the counter medications or supplements, please attach a list of medications if needed.

1	2
3	4
5	6

Please Check if you have or had any of the following medical conditions:

Aids/HIV ☐	Cancer ☐	Head Injury ☐	Kidney Disease ☐	Radiation ☐	Blood disease ☐
Chemo ☐	Anemia ☐	Heart disorder ☐	Liver Disease ☐	COPD ☐	Heart Attack ☐
Blood Disorder ☐	Heart Murmur ☐	Rheumatic Fever ☐	Stroke ☐	Arthritis ☐	Fainting ☐
Hepatitis-Type? ☐	Sinus Problems ☐	Blood Transfusion ☐	Diabetes ☐	Joint Replacement ☐	High Blood Pressure ☐
Lung Disease ☐	Tuberculosis ☐	Herpes/Fever Blisters ☐	Epilepsy/ Seizures ☐	Excessive Bleeding ☐	Asthma ☐
Cardiac Pacemaker ☐	Anxiety ☐	Psychiatric care ☐	Thyroid Conditions ☐	Other (not listed) ☐	Respiratory problems ☐

Patient Signature: _____ Date: _____

Leavenworth Family Dental; PA
4500 S 4th Street Lv,KS 66048
Dr. John McKnight DDS

Insurance and Financial Policy

At Leavenworth Family Dental, we believe that you deserve the best care. That's why we always present to you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits, but some don't. If you have dental benefits, congratulations! You are fortunate. Here are some important things you should know.

- Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion o your dental care. It is only meant to assist you.

- We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the tie of service. We estimate your portion based on the most up to date information we have, but is is **only an estimate**. If you would like to know your insurance benefit, we will be happy to file a " pretreatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does not delay treatment but will give you the exact out of pocket figures you may inquire.

- We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Leavenworth Family Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance company you have is a legal contract between **you** and your insurance company. Our office is not,and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

- Leavenworth Family Dental does require payment in **full** for your portion at the time of service. We accept all major forms of credit/debit cards, cash or check. If you are in need of an extended finance option, we also work with Care Credit "same as cash" or longer terms with interest bearing revolving chargers designed to meet your treatment plan needs on approved credit. Pre-payment **Will Be** required for specific treatment procedures.

- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **24 hour notice.** For the first offense a letter will be sent, and for any recurring offenses a $50.00 cancellation fee **will** be charged, and possible dismissal from the dental practice.

I agree with the above conditions.

Print patient name: _____

Patient signature: _____ Date: _____

Leavenworth Family Dental Privacy and HIPPA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

-Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

-Obtaining payment from third party payers (e.g. my insurance company)

-The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date:_____

Print Patient Name:_____

Signature:_____

Relationship to Patient:_____

Leavenworth Family Dental Authorization and Release

I give authorization and permission to confirm appointments,discuss account information or medical/dental diagnosis via the following option (s) please select all that apply. Please list any person(s) with whom we may discuss these with as well, if none please check the " none" box, this applies to any person(s) 18 years or older. I certify that I have read and understand the above to the best of my knowledge. The above questions have been answered to the best of my knowledge. I understand false information can be dangerous to my health. I authorize the dentist to release information including diagnosis and records of treatment including account information that have been rendered to third party payers/or health care practitioners. I authorize and request my insurance company to pay directly to the dental office or dental group insurance 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 mine or child's behalf.

☑ text ☐ Call home ☐ Call cell ☐ Call work. ☐ E-mail: _____ ☐ None: (don't discuss with anyone other than myself?

Name (of person we may discuss appointments/treatment or accounts with): _____

Relationship to Patient:_____ Phone Number _____

Signature of Patient: _____Print Patient Name: _____Date: _____