Patient Registration

First Name: _____ Last Name:_____ Middle Initial: _____
Preferred Name:_____
Patient Is: ____ Policy Holder ___ Responsible Party___ Neither_____

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:_____
Birth Date: _____ Soc Sec:_____ Drivers License:_____
___ Responsible Party is Policy Holder for Patient __Primary Insurance Policy Holder __ Secondary Policy Holder

Patient Information
Address: _____ Address 2:_____
City: _____ State/ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Sex: ___Male ___ Female
Marital Status:___ Married ___ Single ___ Divorced ___ Separated ___ Widowed
Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers License:_____
EMAIL: _____ For patient confirmation of appointments and specials
Accepts Text Message: _____
Previous Dentist: _____ Phone Number: _____
Preferred Pharmacy: _____ Phone Number:_____
Employment Status_____ Full Time _____ Part Time ____ Retired
Employer:_____ Employer Address: _____
Occupation:_____
Student Status: _____ Full Time ___ Part Time

Primary Insurance Information
Name Of Insured: _____ Relationship to Insured: __ Self ___ Spouse ___ Child ___ Other
Insured Social Security: _____ Insured Birth Date: _____
Insured ID number: _____ Group Number: _____
Insurance Company: _____
Address: _____
Address 2:_____
City, State, Zip: _____

Secondary Insurance Information
Name Of Insured: _____ Relationship to Insured:__ Self ___ Spouse ___ Child ___ Other
Insured Social Security: _____ Insured Birth Date: _____
Insured ID Number: _____ Group Number: _____
Insurance Company: _____
Address: _____
Address 2:_____
City, State, Zip: _____

Patient Name_____

Whom may we thank for referring you?_____

Spouse's Name_____ Birth Date_____

Employer_____

Work #_____ Cell #_____ SS#_____

Relative/ Friend not living with you:

His/Her Name:_____Relationship:_____

Cell #_____ Home #_____

Dental History:

Reason for today's visit:_____

Last dental visit:_____ Last Dental Cleaning:_____

Please Circle

Are you currently in pain?	Yes	No
Do you require antibiotics before a dental visit?	Yes	No
Rate current dental health:	Good	Fair Poor
Do you brush daily? Yes No How many times/daily? _____		
Do use a manual or electric toothbrush? _____		
Do you floss? Yes No How often if yes? _____		
What type of bristles on your toothbrush?	Hard	Medium Soft
Do you have family history of gum disease?	Yes	No
Have you ever had gum treatment?	Yes	No
Have you ever had periodontal disease?	Yes	No
Have you ever had scaling and root planing?	Yes	No
Are your teeth sensitive to heat, cold, or anything else?	Yes	No
Do you have mobility in your teeth?	Yes	No
Do you still have wisdom teeth?	Yes	No
Do you crunch on ice?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you have a biteguard?	Yes	No
Would you like fresher breath?	Yes	No

How many soda/sports drinks do you drink daily? (1 can = 12oz.) _____

Do you drink alcohol? _____ If so, how many drinks per week _____

Have you been a smoker or chewed tobacco?	Yes	No
When_____ How long_____		
Do you still smoke or chew?	Yes	No
Do you, or have you ever had an eating disorder?	Yes	No
Do you have sleep apnea?	Yes	No
Have you had orthodontics?	Yes	No

If so how long did you wear braces? _____

Do you wear a retainer?	Yes	No
Do you like the appearance of your teeth, your smile?	Yes	No

If not, explain_____ _____

Are your teeth all in alignment (straight)?	Yes	No

If not, explain_____

Do you have spaces between your teeth that you don't like?	Yes	No

If yes, explain_____

Do you like the color of your teeth?	Yes	No

If not, explain_____

What would you like to change the most in the appearance of your teeth?

_____

Signature_____ Date _____

Michelle B Deutch D.D.S.

Eaglesoft Medical History

Patient Name: Birth Date:

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	If yes
Do you smoke or chew tobacco?	○ 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?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Seasonal Allergies	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Yellow Jaundice	○ Yes ○ No	Depression	○ Yes ○ No	Premedication	○ Yes ○ No	Anxiety	○ Yes ○ No
Heartburn/Reflux	○ Yes ○ No						

Have you ever had any serious illness not listed ○ Yes ○ No If yes

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 Date:_____

Michelle B. Deutch, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____

Signature _____

Date _____

For Office Use Only

We attempt to obtain written acknowledgement of receipt of our Notice of Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

This form is educational only, and does not constitute legal advice, and covers only federal, not state law (August

Michelle B. Deutch, D.D.S.

NOTICE OF PRIVACY PRACTICES

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 April 14, 2003, 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 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 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 at the end of the notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider provident treatment to you.

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

Healthcare operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare 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 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 a 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 healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in care: We may use or disclose 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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 reasonable 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 or the 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 activities. We may disclose to correctional institution or law enforcement official having lawful custody or 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 voicemail messages, postcards, emails, 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 $.25 for each page. $3.00 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 that treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

Restrictions: 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 those 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 how payments will be handled under the alternative means or location 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 (email), you are entitled to receive this notice in written form.

QUESTION 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 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 also may 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 on 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 Officer: Sandy Curtis- Office Administrator

Telephone: 913-469-0085 Fax: 913-730-1930

Email: mbddds@aol.com

Address: 8575 W. 110th Street, Suite 326, Overland Park, Ks. 66210

Financial Policy

Thank you for choosing us as your dental health care provider. We look forward to assisting you in attaining optimum oral health.

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment. All patients must also complete our Patient Information Form as well as your insurance form, if required by your plan, before seeing the doctor.

Full Payment Is Due At The Time Of Service unless other financial arrangements have been made in advance. We accept cash, check, Master Card, Visa, and Discover cards. Other financial services are available through Wells Fargo.

A monthly billing fee of 1.5% or $5.00, whichever is greater, will be added to all accounts that remain unpaid after 60 days. If it becomes necessary to use other means for collecting payment, the patient is responsible for any and all costs, fees, and attorney fees incurred.

Regarding Insurance

Our office requires that you pay your deductible and co-payment, if applicable, at the time of service. While every effort will be made to maximize your insurance benefits, **the balance is your responsibility, whether your insurance company pays or not.** If your insurance company has not paid your claim within 60 days, the balance will be automatically billed to you. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your policy.

We will file insurance claims for you if you bring all insurance information and a completed insurance claim form, if required by your plan. **Information regarding insurance benefits is the responsibility of the patient.** Estimates given by our office are not a guarantee of benefits. We cannot be held responsible for the benefits paid, or not paid, by your insurance company.

Emergency Care

All emergency care patients are expected to remit payment at the end of the appointment.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please have the courtesy to give us at least 48 hours notice so that we may help serve other patients wanting treatment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read this Financial Policy, and understand and agree to this Financial Policy.

_____

Print Name

_____ _____

Patient or Responsible Party Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Dr. Michelle Deutch to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available upon request.

Patient authorizes communication with family/friends regarding your care and test results.

Name_____ Phone #_____ Relation _____

Name_____ Phone #_____ Relation _____

Patient authorizes communication with family/friends regarding your account and billing.

Name_____ Phone#_____ Relation _____

Name _____ Phone # _____ Relation _____

Patient authorizes communication with a primary care physician or other physician (first and last name):

1._____ Phone # _____

2. _____ Phone # _____

Best way to contact you regarding messages, responses, appointment reminders etc. (mark all that apply).

Home phone__ Work Phone __ Cell Phone __ Email __

May we leave a message with whomever answers the phone or on voicemail?

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

May we fax and/or email to other providers if necessary for medical care? Yes No NA

Signature of patient (or patient's representative) _____

Printed legal name of patient (or patient's representative) _____

Date _____

CREDIT/DEBIT POLICY

PATIENT NAME _____

I understand it is the policy of Michelle Deutch, D.D.S. to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with the provisions of the U.S. law.

If, after a claim has been submitted to my insurance carrier: 1) the claim is denied for any reason: OR 2) there is a patient liability (I.E. Deductible, Co-insurance, etc.) the office will send a statement notifying me of the balance. If this amount is not paid within 60 days, then my credit or debit card will be charged for the entire balance owed for treatment of services to me.

I understand my insurance company will also provide notification of these charges with an explanation of benefits. In the event this amount exceeds $250.00, the office will provide a courtesy call to my phone number.

I understand that in the event my credit or debit card has been charged for treatment or services, and then my insurance carrier subsequently makes a payment to the office for those charges, the office will issue a credit to my credit or debit card.

PLEASE CIRCLE ONE OF THE FOLLOWING:

VISA, MC, AMERICAN EXPRESS, OR DISCOVER

CARD/ACCOUNT NUMBER _____

EXPIRATION DATE _____ Security Code _____

NAME OF CARDHOLDER _____

I hearby authorize Michelle B Deutch, D.D.S. and its designated employees to charge my credit/debit card as designated above.

_____ _____

Cardholder's Signature Date