- **Patient Information:** Date:________

Name: ____ □ Married □ Single □ Minor □ Male □ Female
Last First Middle Preferred

Birth date: _______________ S.S.N.#____________________ ID/DL#:_______________________
Month /Day /Year

Address: ____
Street Apt. # City State Zip

Telephone: _________________________ ___________________________ _______________________
Home # Work# - Ext Other

Email: ____ Preferred: □Home □Work □Other □Email

Place of Employment (or School):___________________________ Position (or Grade):_________________

Dental Insurance Co.:_________________________________ Group / Plan #:____________________

Payment for today's visit: □ Cash □ Check □ Credit Card How did you hear about us? ________________

- **Family Information (Parent Information Required if Dependent Child)**

	Father (or Husband)	Mother (or Wife)
Name:	____________________ Last First Middle	____________________ Last First Middle
Address:	____________________ Street City State Zip	____________________ Street City State Zip
Telephone #:	( ) ________ ( ) ________ Home Work	( ) ________ ( ) ________ Home Work
Birthdate / S.S.N.	____________________ Month/Day /Year S.S.N.	____________________ Month/Day /Year S.S.N.
Employer:	____________________ Employer	____________________ Employer
Dental Ins. Co.:	____________________ Dental Insurance Company Group / Plan #	____________________ Dental Insurance Company Group / Plan #

- **Person Responsible For Your Dental Account:** □ Patient (self) □ Father / Husband □ Mother / Wife
- **Person to contact in case of emergency: (Outside of immediate family)**

Name______________________________________ Tel #__________________
Last First M

Address____
Street City State Zip

- **Dental Emergencies:** We are available to our patients 24 hours a day. If you have an after hours emergency and you have been seen in our office in the last three years, please call our office number: (785) 843-9122. An after hours appointment fee will be charged if you have not been seen within the last three years in our office.

Signature of Responsible Party:

______________________________________ **Date:____________________**

Patient Financial Policy:
In order to help maintain a good relationship with our patients, JayHawk Dental LLC has adopted a written financial policy. The purpose of this policy is to eliminate the confusion or misunderstanding concerning financial arrangements offered by our office. Our office communicates this policy to each patient.

For our patients with insurance benefits, please note that although we are happy to bill your insurance carrier as a courtesy, *the insurance contract exists between the carrier and the insured*. We will accept insurance assignment, but can not guarantee payment of benefits. Any questions regarding your benefits should be directed to your insurance carrier.

1. **Payment at time of service is required**. The patient is required to pay the **estimated** portion of their bill that the insurance will not cover when treatment is rendered. JayHawk Dental LLC accepts Visa and MasterCard cash or check. If the patient **does not** have dental insurance, the patient is responsible for **payment in full** at **time of treatment**.

2. A statement of services rendered will be mailed at the end of each month. Receipt of payment is required within 10 days from the statement date.

3. While the staff will make their best attempt to get accurate benefit information, any balance due after insurance pays is the patient's responsibility. A late fee of 1.5% per month will be assessed and will appear on any subsequent statements. The annual percentage rate is 18%.

4. A **$30.00** charge will be billed to the patients account for any check returned by the bank for any reason not paid.

5. All accounts unpaid after 90 days from the time of service are considered delinquent. Delinquent accounts will be sent to a collection agency and reported to the Credit Bureau. Collection and legal fees will be added to your account.

6. There is a **$75.00** charge for missed appointments or broken appointments with less than 24hrs notice.

- **Financial Authorization:** I have read and understand the financial policy of JayHawk Dental LLC and agree to all the terms described therein. I hereby authorize payment to JayHawk Dental LLC the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I agree that any dispute about the reasonableness or computation of fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services by any member of JayHawk Dental LLC staff or our doctors, shall be submitted to binding arbitration. It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against each other, arising out of this agreement, all disputes shall be resolved through arbitration.
- **HIPAA Authorization:** I authorize the release of information to all my insurance companies. I authorize my doctor to submit all claims to my insurance company. I hereby authorize payment directly to JayHawk Dental LLC of the group insurance benefits otherwise payable to me. I hereby authorize JayHawk Dental LLC to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I am aware that this office is in compliance with HIPAA as of August 1, 2003. The information I have provided on this page is correct to the best of my knowledge.

Signature of Responsible Party:

____________________________________ **Date:____________________**

HEALTH AND DENTAL HISTORY

- **Patient Information:** Date:________

Name:____
Last First Middle

How long has it been since your last dental visit?________________

Have you ever been diagnosed with any of the following? Please check all that apply:

- □ AIDS
- □ Allergies:_________
- □ _________________
- □ Anemia
- □ Arthritis
- □ Artificial Joints
- □ Blood disease
- □ Cancer
- □ Diabetes
- □ Dizziness
- □ Epilepsy
- □ Asthma
- □ Excessive Bleeding
- □ Fainting
- □ Glaucoma
- □ Growths
- □ Hay Fever
- □ Head injuries
- □ Heart Disease
- □ Heart Murmur
- □ Hepatitis
- □ High Blood Pressure
- □ Jaundice
- □ Kidney Disease
- □ Liver Disease
- □ Mental Disorders
- □ Nervous Disorders
- □ Pacemaker
- □ Currently Pregnant
  Due Date:___________
- □ Radiation Treatment
- □ Respiratory problems
- □ Rheumatic fever
- □ Rheumatism
- □ Sinus problems
- □ Stomach Problems
- □ Stroke
- □ Tuberculosis
- □ Tumors
- □ Ulcers
- □ Venereal Disease
- □ Codeine allergy
- □ Penicillin allergy
- □ Tobacco use

OTHER:

- □ Rx: PhenPhen
- □ Mitral Valve Prolapse
- □ __________________

Have you been admitted to a hospital or needed emergency care in the past two years? _____yes _____no
If yes, please explain:____

Have you had surgery in the last 5 years? _____yes _____no. If yes, what for:_____________________

Are you currently under a Doctor's care for a specific health issue? ______yes ______no
If yes, please give physicians name and phone number:____________________________________

Please list all medications you are currently taking, use the back of this sheet if necessary:
____

What brings you to our office today?____

Do you have any specific areas of concern or problems?____

Are you happy with the appearance of your teeth and smile?_______________________________________

Have you ever had any problems with any of the following; please check all that apply

- □ Bleeding or sore gums
- □ Bad breath or taste
- □ Burning Tongue
- □ Blisters or cold sores
- □ Periodontal (gum) disease
- □ Clenching / grinding your teeth
- □ Cracked, broken or worn teeth
- □ Loose teeth
- □ Shifting or movement of teeth
- □ Missing teeth
- □ Food sticking between teeth
- □ Hot / Cold Sensitivity
- □ Sensitivity to sweets
- □ Sensitivity to chewing / biting
- □ Stained or yellow teeth

Signature__________________________________ **Date:**____________________

JayHawk Dental LLC

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 (MM/DD/YR), 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 the 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 new 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 listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing 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 healthcare 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 judgment 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 reasonably 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 of 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, 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 you $0.25_ for each page, $10 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 than 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.

Restriction: 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 these 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 you 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 (e-mail), you are entitled to receive this Notice in written form.