OAK PARK DENTAL GROUP

12148 W. 95 Street
Lenexa, Kansas 66215
913-492-9660

First Name:_____ **Last Name:**_____**MI:**____ **M**___**F**____

Social Security#_____**Birthdate**_____**Home#**_____
Work#_____ **ext**_____**Cell#**_____**E-Mail:**_____
Address _____**City**_____**State**_____**Zip**_____
Policy Holder Name_____**Birthdate**_____**Group Name**_____
Group#_____**Policy Holder #**_____**Secondary Insurance**_____
Referred by_____

TELL US ABOUT YOUR MEDICAL HISTORY

How would you describe your health? Please circle one Excellent Good Fair Poor
When did you have your last physical examination?_____
Are you currently being treated for any illness or medical condition? Yes_____ No_____
If yes, please describe_____
_____Who is your primary care **physician**?_____
Have you ever had any surgery? Yes____No____When did you have it?_____
What type of surgery did you have?_____
Have you ever had any trouble with prolonged bleeding after surgery?_____
Do you have a pacemaker or any kind of artificial joint? Yes___No___ Which?_____
Are you taking any medications or drugs at this time? Yes____No____
What medications are you taking?_____
_____
Why are you taking these medications?_____
Ever had a reaction or complication to local anesthetic or **drug** (like Novocain or penicillin)? Yes___No____
If yes, please explain_____

Please **circle** any present or past illness you now have or had in the past:

Alcoholism	Diabetes type____	Herpes	Nervous or Anxious
Allergies	Drug Dependency	High Blood Pressure	Neurologic Disorder
Anemia	Emphysema	HIV/AIDS	Respiratory Disease
Artificial Heart Valve	Epilepsy	Infectious Diseases	Rheumatic Fever
Artificial Joint	Fainting or Dizziness	Kidney Disease	Sickle Cell Disease
Asthma	Glaucoma	Latex Sensitive	Sinus Trouble
Bleeding Disorder	Head/Neck Injuries	Liver Disease	Take Cortisone
Bruise Easily	Heart Disease	Lupus	Stroke
Cancer	Heart Murmur	Mental Illness	Swollen Ankles
Chemo or Radiation	Heart Surgery type____	Migraines	Tuberculosis
Chest Pain	Hepatitis type ____	Mitral Valve Prolapse	Ulcers

Do you smoke or use tobacco products? Yes_____No_____
Are you allergic to Latex or any other substances or materials? Yes_____No_____
If yes, please explain_____
If female, are you pregnant? Yes____No____What month?_____Are you nursing? Yes____No____

Is there any other information that should be known about your health?_____

Signature of Patient
(Or Guardian)_____Date_____

Consent to Treat

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient's or Guardian's Signature_____Date:_____

Financial Agreement

Patient Name:_____ Social Security #_____ DOB:_____

With Dental Insurance

Your Dental insurance is your responsibility. Regardless of what we may calculate as your dental benefit dollar, we must stress the fact that you, the patient are responsible for the TOTAL DENTAL TREATMENT FEE. As a courtesy to you, we do accept assignment of benefit payment from most insurance companies. We allow 60 days for insurance payment. AFTER THAT TIME PERIOD ALL INQUIRIES(FOLLOW UP ON PAYMENTS DUE) BECOME YOUR RESPONSIBILITY. Remember you have the contract with the insurance company.

Signature:_____Date:_____

Without Dental Insurance

I agree to the FINANCIAL RESPONSIBILITY of my total treatment fee. The fees quoted will be honored for 90 days from the below date. After this time, the fees are subject to adjustment in accordance to our costs.

Signature:_____Date:_____

_____

_____

Acknowledgement of Receipt of Notice of Privacy Practice

(You may refuse to Sign this Acknowledgement)

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

_____

Please Print Name Here

Signature_____ Date:_____

For office use only

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

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other_____