CURTIS ALEXANDER, D.D.S.

Today's Date_____

Name_____Date of Birth_____

Address_____Sex_____

City_____State_____Zip Code_____

Home Phone_____Marital Status_____S.S.#_____

E-Mail Address_____Cell phone_____

Employed by_____Driver's Lic.#_____

Employers Address_____

Work Phone_____

SPOUSE, PARENT OR GUARDIAN THAT IS THE POLICY HOLDER OF THE INSURANCE ON THE PATIENT:

Name_____Date of Birth_____

Address_____Sex_____

City_____State_____Zip Code_____

Home Phone_____Marital Status_____S.S.#_____

Employed by_____Driver's Llc.#_____

Address_____

Work Phone_____

Name Address & Phone of Spouse or Parent if different than the policy holder:

_____

Person to contact in case of **EMERGENCY:**

Name_____

Address_____

Phone Home_____Cell_____

Person **RESPONSIBLE** for this account?_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

_____

Time 8:23 AM | Curtis Alexander DDS | Date 6/1/2016

New(Copy)

Patient Name: | Birth Date: | Date Created:

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	
Do you use tobacco?	Yes No	
Do you drink alcohol or beer?	Yes No	

Women: Are you pregnant, what month 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
☐ Acetametophen	☐ Tylenol	☐ Valium	☐ Demerol
☐ Percodan	☐ Darvon	☐ Tetracycline	

Do you use controlled substances?	Yes No	If yes	
Other?	☐	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	Hay Fever	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	Heart Surgery	Yes No	Skin Disease	Yes No	Nervousness, Emotional Problems	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. I grant authority to the dentist and staff to perform the examination and if needed, treatment. I agree to pay court costs and attorneys fees if any delinquent balance is placed. I further understand that a 1.5% finance charge(18% annually) will be added to my balance over 60 days.

Signature of Patient, Parent or Guardian:

X _____ Date:_____

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ALEXANDER
D.D.S.
General Dentistry

IMPORTANT INFORMATION REGARDING

YOUR INSURANCE COVERAGE

You understand that your insurance is a contract between you, your employer and your insurance company. ____(Initial)

You understand that you are personally responsible for all the fees associated with professional services rendered by this office including any amounts not reimbursed by your insurance. You understand that any written estimate of benefits, pre-authorizations or verbal assurances obtained from your insurance carrier DO NOT necessarily guarantee payment of benefits. _____ (Initial)

You understand Dr. Alexander DOES NOT work for or allow insurance companies to dictate your dental care. Dr. Alexander's treatment plans are based on his professional opinion and your need for dental care._____(Initial)

You understand your insurance company is directly responsible to you under the terms of your policy. We will file your insurance as a courtesy. We have elected to participate with certain insurance plans as a provider and accept the contracted payment schedule. We will provide all insurance information needed to facilitate payment, and assist you to obtain your greatest benefits; however, it is YOUR responsibility to resolve any insurance disputes._____(Initial)

Date_____ Signature_____

I do NOT have dental insurance to file and I understand that I am responsible for all charges incurred for all dental treatment on the day services are rendered.

Date_____ Signature_____

300 Platte Clay Way • Kearney, MO 64060 • 816.628.4997

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ALEXANDER
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General Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including revisions of our notice at any time by contacting Dr. Alexander's office at 816-628-4997.

Right to Revoke: You have the right to revoke this consent at any time by providing a written notice of your revocation and submitting it to our office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I,_____ have received a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and Health care operations.

Signature:_____ **Date:**_____

You are entitled to a copy of this consent.