Arbor Creek Dental

Dear Patient,

We would like to extend a warm welcome to you! Our goal is to provide you with the finest dental care possible in an environment that recognizes your individuality.

We strive to help you attain and maintain an excellent level of oral health for a lifetime. Your thoughts, opinions and concerns matter! So, feel free to ask any questions or bring up any issues or concerns that are important to you.

Please fill out, print and sign the following forms and bring them completed to your initial visit. If you are filing insurance for your appointment, please bring your dental insurance card or have the Member ID and Group Number available. Our team is looking forward to meeting you soon.

Sincerely,
Jason Knag and Team

Our Three Commitments to You

A commitment between two people binds trust; I have three important commitments in my practice. I have put them in writing because I live by them, as does my team. I realize that the institution of these commitments may be different from what you may have been accustomed to in other dental practices; however, I believe that these commitments are necessary in building the trust that it takes for you and I to successfully work together.

Commitment to Treatment

Dental disease is nearly 100% preventable. Therefore, I believe that all treatment begun should be completed. I will deliver the best dental care that I am capable of delivering to you, and I ask that you care for your dental health on a daily basis to the best of your ability. Incomplete treatment leads to unnecessary problems and complications, such as the loss of teeth. It also leads to more advanced disease complications, such as the loss of teeth. It also leads to more advanced disease which unnecessarily adds to your cost and can lead to a breakdown in communication between the two of us. I understand that you likely want as little dentistry done in your lifetime as possible. Help yourself achieve that goal by following through with your dental plan.

Commitment to Appointment

I will reserve time especially for you in my schedule. I will give you my utmost attention and care and will rarely keep you waiting. An appointment scheduled in my office is a bond of trust that my team and I will be here to serve you and that you will be on time and prepared for your appointment.

Commitment to Financial Considerations

I believe that I have a responsibility to use my best professional care; skill and judgment in helping you achieve your dental health goals. As I have stated above, I believe dental disease is nearly 100% preventable. I will deliver the best dental care that I am capable of delivering to help attain your goals. It is up to you to make financial arrangements with my practice to pay for your services.

Jason Knag D.D.S.
15990 South Bradley Drive Olathe, Kansas 66062
Phone: (913)390-5300 Fax: (913)390-5310

PATIENT INFORMATION

Name:_____ Prefer to be called:_____Male or Female
First Middle Last

Address: _____
Street City State Zip Code

Home Phone:_____Work Phone:_____
Cell Phone:_____Email:_____
Birthdate:_____Patients Social Security #:_____
How would you prefer to be contacted:_____(phone, email, letter)
( )Minor ( )Single ( )Married ( )Divorced ( ) Widowed ( ) Separated
Patients Employer: _____Occupation:_____
Business Address:_____

If Patient is a Minor:

Parent's Name(s):_____
Employer:_____Work Phone:_____
Contact Number:_____
If patient is a student, name of school/college:_____

Emergency Contact Information:

In the event of an emergency, who should we contact? Name:_____
Relationship:_____Home #:_____Work #:_____

Whom may we thank for referring you? Name:_____
( ) Location ( ) Mailer/Flyer ( )Insurance ( )Yellow Book ( ) Internet ( ) Referral

INSURANCE INFORMATION fill out as person carrying the insurance_____

Name of Dental insurance:_____Insurance Subscriber's name:_____
Insurance Address:_____
Subscribers Social Security #:_____ID #:_____
Subscribers Birthdate:_____Employer:_____
Cell:_____Work Phone:_____Home Phone:_____
Group #:_____* Please provide a copy of your insurance card

What is the reason for your visit today?_____

Date of last dental visit:_____What was done at your last dental visit?_____
Do you have any dental problems now? YES NO Explain:_____

Are you satisfied with your teeth's appearance? YES NO
What would you change about your smile?_____
Are you interested in white teeth? YES NO
Do you brush, floss or use any dental aids?_____

Do you feel anxious or nervous about receiving dental treatment?_____

Name:_____ Date:_____

MEDICAL HEALTH HISTORY

Physician:_____ Office Phone:_____ Date of Last Exam:_____

Medical Alert_____

1. Are you under medical treatment now?_____
2. Have you ever been hospitalized for any surgical operation or serious illness?_____
3. Are you taking any medication? Including non-prescription medication?_____

Please list all medications:_____

4. Do you use tobacco? YES NO
5. Do you use alcohol? YES NO
6. Do you use cocaine or other recreational drugs? YES NO
7. Are you wearing contact lenses? YES NO
8. Have you taken any bisphosphonate drugs?(ex:actonel, boniva, fosamax) YES NO
9. Are you allergic to or had any reactions to the following: (please circle)

•Local anesthetic •Sulfa Drugs •Penicillin •Aspirin
•Sedatives •Codeine •Iodine •Other

Other antibiotics_____

10. **WOMEN ONLY:**

a)Are you pregnant or think you may be pregnant? YES NO
b)Are you nursing? YES NO
c)Are you taking birth control pills? YES NO

11. Circle any of the following which you have had or have at present:

AIDS or HIV Infection	Fainting/Seizures	Low Blood Pressure
Alcoholism	Frequently Tired	Mitral Valve Prolapse
Anemia	Glaucoma	Nervousness
Angina	Hay Fever/Allergies	Psychiatric Treatment
Arthritis	Heart Attack	Radiation or Chemo Therapy
Artificial Heart Valve	Heart Disease	Recent Weight Loss
Asthma	Heart Murmur	Respiratory Problems
Cancer	Heart Trouble	Rheumatic Fever
Cardiac Pacemaker	Hepatitis/Jaundice	Sexually Transmitted Disease
Chest Pains	Herpes	Stent/Stint
Cold Sores	High Blood Pressure	Stomach Trouble/Ulcers
Congestive Heart Failure	Joint Replacement/Implant	Stroke
Diabetes	Kidney Disease	Swollen Ankles
Drug Addiction	Latex Allergy	Thyroid Problem
Easily Winded	Leukemia	Tuberculosis
Emphysema	Liver Disease	Other_____
Epilepsy/Convulsions		

PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing or flossing? YES NO
2. Are your teeth sensitive to hot or cold liquids/foods? YES NO
3. Are your teeth sensitive to sweet or sour foods/liquids? YES NO
4. Do you feel any pain to any of your teeth? YES NO
5. Do you have any sores or lumps in or near your mouth? YES NO
6. Have you had any head, neck, or jaw injuries? YES NO
7. Do you have frequent headaches? YES NO
8. Do you clench or grind your teeth? YES NO
9. Have you had any orthodontic work? YES NO
10. Do you have any problems with your jaw? (Clicking, Pain, Locking) YES NO
11. Have you ever had a difficult extraction in the past? YES NO
12. Have you ever had prolonged bleeding following an extraction? YES NO
13. Have you ever had correct instruction for brushing and flossing? YES NO
14. Have you ever had instructions on the care or your gums? YES NO

Financial Policy

We thank you for selecting Arbor Creek Dental office for you dental needs. We will strive to provide the very best care for you. In order to do so, this sheet has been prepared to acquaint you with our financial policies.

Please be advised that for those patients or procedures without insurance coverage, payment is due in full as the services are rendered. For your convenience we accept cash, check, MasterCard, Discover Card and American Express. We also offer Care Credit Healthcare Financing applications or go online to carecredit.com for information.

Insurance Assignment and Management

In order to better serve your needs, our office contracts with **Blue Cross & Blue Shield, Delta Dental KS, Guardian and Met Life Insurance** Plans. We will be happy to assist you in filing any insurance however, it is up to each patient to know and understand the coverage, benefits, limitations, waiting periods, an exclusions of their own insurance plan. We will not be responsible if you do not follow the specific terms of your insurance agreement. Patients are responsible for paying their deductibles and co-pays at the time of service. Deductibles and co-pays are **ESTIMATED** for what benefits may be available. Please be advised that these estimates are just that, **ESTIMATES** to the best of our ability. We would be happy to pre-authorize any treatment at your request however; even pre-authorizations are not a guarantee of payment from your insurance company. Ultimately, you are responsible for any balances from unpaid claims.

We will be more than happy to file insurance claims for you in a prompt manner. We do not accept or file medical insurance. In order for us to file dental insurance on your behalf you must provide us with proper insurance information at the time of visit. If you are not able to provide this information or we are unable to verify your dental coverage, you will be required to pay in full at the time of service or you may choose to reschedule your appointment.

Please be advised that any balance on account that is over 60 days will be charged a finance charge of 18% annually (1.5% per month). Accounts that remain delinquent may be turned over for collection action with our attorney or collection agency.

BROKEN APPOINTMENTS: 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 to avoid a **$50.00 Cancellation Fee**. (True emergencies are an exception)

Acknowledgement and Agreement

I certify that I have read, understand, accept and agree to abide, with all the terms of the financial policy above. I will not hold Arbor Creek Dental or any employee responsible for omissions I have made in the completion of information. If I provide insurance information to Arbor Creek Dental, I authorize Arbor Creek Dental to release information regarding my treatment for the purpose of filing for potential payment of insurance benefits and I grant assignment of any such proceeds to Arbor Creek Dental. *I understand that Arbor Creek Dental is not allowed to give out any information to any person(s) unless I have them listed as follows*:

(**Signature Required**)

_____ _____

Please print name of financially responsible party

Signature of financially responsible party

Composite Resin Fillings Consent Form

This is to inform you that our office strives to use only the best, most appropriate up-to-date materials for restorations. Because of this, we no longer use amalgam (silver fillings) in our practice and use only composite resin (tooth colored fillings) materials, porcelain and or gold.

Unfortunately, some insurance companies have not caught up to the current standards. They may give an "alternate benefit" for this procedure using an amalgam or metal filling rate. Therefore, it is in your best interest to know what your insurance policy covers as you will be responsible for any unpaid portion.

Should you have any questions or concerns regarding composite resin restorations, we would be happy to discuss it with you. Please sign below to acknowledge that you have read and understand the above information.

_____	_____	_____
Printed name of Patient	Signature of patient or parent if minor	Date

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 12/16/2008 and will remain in effect until it is amended or replaced by us.

It is our right to change privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use or disclose your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or person you CHOOSE to involve in your care only if you agree that we may do so.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: we may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

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.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or Administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Health-Related Services: We may use intraoral and, extraoral images in furthering education to others by including them in a before and after treatment book. We may use extraoral images to encourage patient participation and promote office activities.

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 a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders including, but not limited to voicemail messages, postcards, or letters.

YOUR PRIVACY RIGHT AS OUR PATIENT:

Access: Upon written request, you have the right to inspect or get copies of your health information, (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. IF you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $5.00 for each page and the staff time charged will be $10.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a profession for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available). You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting December 16, 2008. Information prior to that date would not have to be released.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact your Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a complain form from our Privacy Officer. 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.

HOW TO CONTACT US:

Practice Name: Arbor Creek Dental
Privacy Officer: Jason Knag DDS
Telephone: 913-390-5300
Address: 15990 S. Bradley Dr., Olathe KS 66062

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices and have read the contents. I understand that I am giving my consent to use and disclose my health care information to carry out treatment, education, payment activities and health care options.

_____
Please Print Your Name Here

_____ _____
Signature Date

HIPAA Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, laws.

Medical Information Release Form
(HIPAA Release Form)

Name:_____ Date of Birth: ____/_____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

( ) Spouse_____
( ) Child(ren) _____
( ) Other_____

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ( ) My Home ( ) My Work ( ) My Cell Number: _____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call
( ) other:_____

The best time to reach me is (day) _____between (time) _____

_____ _____
Signature Date

Dental Inquiry

Patient Name: _____

Welcome to Arbor Creek Dental, this might be the most important dental visit you ever have. We feel that helping you determine your present and future dental needs is the most important service we offer. Although there are issues you have probably never thought of in detail, please answer the following to your best ability.., Thank you!

- What is your primary concern for the visit and what did you want to accomplish?
  - _____
- Have you ever had any unpleasant experiences associated with previous dental offices?
  - _____
- Have you ever been treated for gum disease?
  - _____
- What are your expectations of this office?
  - _____

Treatment Recommendations or Treatment Options

We prefer to give you options based on how you would like to treat your dental health. We are here to make recommendations on how to achieve your goals.

The following questions help us determine what is important to you. Please rate on the following scale from 1 to 10, with **10** being the **MOST** important. (*Please select one*)

1. How healthy would you like your mouth to be?

   1 2 3 4 5 6 7 8 9 10

2. How preventive (or proactive) would you like to be regarding your dental health?

   1 2 3 4 5 6 7 8 9 10

3. How important are dental cosmetics to you? (Example: whitening, straighter teeth, etc.)

   1 2 3 4 5 6 7 8 9 10

Anything else you would like to mention so we may provide you with the BEST dental care possible?

_____