Welcome to our Practice

Thank you for trusting us with your dental care. Our goal is to provide you with the finest care possible. Would you please be kind enough to answer the following questions to assist us in treating you.

Keystone Dentistry
109 Apple Valley Parkway
Belton, MO 64012
816-331-4200

Date ____________________

PATIENT INFORMATION Responsible Party ☐

Legal Name____ Home Phone (____) _____________

Address____ Work Phone (____) _____________

City_______________________ State________ Zip_________________ Cell Phone (____) _____________

Social Security Number _______________ Date of Birth ________________ E-mail address______________________

Sex ☐ M ☐ F Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Primary Physician________________________________ Phone (____) ____________

Landlord________________________________ Phone (____) ____________

Financial Institution________________________________

How were you referred to our office? _______________________________________

Who may we thank for referring you?_______________________________________ Phone (___) ____________________

Person to contact in case of emergency, not living in the home_______________ Phone (___) ____________________

Relationship? _____________________________

EMPLOYMENT INFORMATION

Employer_________________________________ Occupation________________________ How Long?_________________

Address____

SPOUSE INFORMATION Responsible Party ☐

Name_____________________________ Work Phone (___) _________ Cell Phone (___) _________

Social Security Number_______________________ Date of Birth_________________

Employer_________________________________ Occupation________________________ How Long?_________________

E-mail Address____

FINANCIAL ACKNOWLEDGEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. If I have insurance, co-payments and deductibles will be due at time services are rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

____

(Patient Signature)

MEDICAL AND DENTAL HISTORY

Patient Name_______________________________ **Date of 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. Because of this, we may ask you to periodically update this form. Thank you for taking the time to answer the following questions.

Reason for visit _______________________________ Approximate date of last dental visit______________

What is your *primary* concern that you would like addressed____

Check (✔) if you have had any of the following:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Click or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

Physician's Name_____________________________ Date of last visit______________________________

Are you under a physician's care now? ☐ yes ☐ no

Have you ever been hospitalized/had a major operation? ☐ yes ☐ no When?__________________________

Have you ever had a blood transfusion? ☐ yes ☐ no When?__________________________

Do you take, or have you taken, Phen-Fen or Redux? ☐ yes ☐ no

Do you use tobacco? ☐ yes ☐ no Do you use controlled substances? ☐ yes ☐ no

Women: Are you pregnant? ☐ yes ☐ no Nursing? ☐ yes ☐ no Taking birth control pills? ☐ yes ☐ no

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other ____________________

Check (✔) if you have, or have had, any of the following:

- ☐ AIDS/HIV
- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve*
- ☐ Artificial Joint*
- ☐ Asthma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack/Failure
- ☐ Heart Murmur*
- ☐ Heart Pace Maker*
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse*
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever*
- ☐ Sickle Cell Disease
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors or Growths

*Condition my require medication

Other medical conditions not listed:____

List medications you are currently taking, *including vitamins, aspirin and over the counter medication*:__________________________

____

I AUTHORIZE MY DENTIST AND/OR CLINICAL TEAM TO TAKE ANY NECESSARY X-RAYS, PHOTOS, OR STUDY MODELS TO ENABLE COMPLETE DIAGNOSIS AND TREATMENT ____

(Patient Signature)

COSMETIC EVALUATION

Rate your smile 1 to 10 (1=I hate my smile; 10=awesome)____ Would you like to have whiter teeth? ☐ Yes ☐ No

What, if anything, would you change about your smile?____

Do you have any special occasions coming up?____

Through the technology of Cosmetic Dentistry, we have an ability to help you achieve a World-Class Smile. Using Computer Assisted Dental Imaging, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Would you like to see what YOU would look like with a new and improved smile? ☐ Yes ☐ No. If yes, please check off all that apply:

- ☐ Lighten all front teeth
- ☐ Lighten single tooth
- ☐ Close spaces between teeth
- ☐ Rebuild fracture(s)
- ☐ Lengthen
- ☐ Shorten
- ☐ Straighten Rotation
- ☐ Straighten Angulation
- ☐ Eliminate Crowding
- ☐ Eliminate dark/stained fillings
- ☐ Reduce gum showing in smile
- ☐ Repair uneven edges

Any other concerns you may have?____

____

Dental Benefit Information

Please Have Dental Benefit Card And ID Ready to Give to Office Staff to Copy - Thank you.

Patient Name ________________________________

PRIMARY CARRIER

Policy Holder ________________________________ SSN____________________ Date of Birth________

Insurance Company ____________________________ Employer ____________________________

Address ____

Phone (____) __________ Group Number _________________________

SECONDARY CARRIER

Policy Holder ________________________________ SSN____________________ Date of Birth________

Insurance Company ____________________________ Employer ____________________________

Address ____

Phone (____) __________ Group Number _________________________

ASSIGNMENT OF BENEFITS

I hereby instruct and direct my Insurance Company(ies) to pay by check made out and mail to **Terry L. Myers, DDS, PC.** A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance.

I understand that by law my employer should provide me with a benefit booklet, of which I should familiarize myself, outlining my dental benefits.

________________________________ ____________ ________________________

Signature of Policyholder Date Office Witness

____

Signature of Parent/Guardian, if other than Policyholder