

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 _____

MINOR PATIENT INFORMATION

Legal Name _____ Home Phone (____) _____
Sex M F Social Security Number _____ Date of Birth _____
Name of School/College _____
Primary Physician _____ Phone (____) _____
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? _____

PARENT/GUARDIAN INFORMATION

Legal Name _____ Home Phone (____) _____
Address _____ Work Phone (____) _____
City _____ State _____ Zip _____ Cell Phone (____) _____
Social Security Number _____ Date of Birth _____ E-mail address _____
Marital Status Single Married Divorced Separated
Financial Institution _____
Employer _____ Occupation _____ How Long? _____
Address _____
Landlord _____ Phone (____) _____

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.

(Parent/Guardian 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Click or popping jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> 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:

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

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

(Parent/Guardian Signature)

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