Michelle Olson, D.D.S.
Quivira Park Family Dentistry
11740 W. 135th St. Overland Park, KS 66221
Phone: 913-955-2300 info@theoverlandparkdentist.com

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:_____ Patient's 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:_____
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 ( ) Internet ( ) Referral

INSURANCE INFORMATION fill out as person carrying the insurance_____
Name of Dental insurance:_____ Insurance Subscriber's name:_____
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 whitening your teeth? YES NO
How often 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? _____

Do you need to take an ANTIBIOTIC PRIOR TO DENTAL TREATMENT? _____

Please list all medications:_____

_____

_____

_____

4. Do you use tobacco? (chewing, cigarettes, e-cigs) If yes, for how many years?	YES NO
5. Do you use alcohol? (wine, beer or liquor)	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 medications to treat osteoprosis?(ex:actonel, boniva, fosamax, reclast, prolia)	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

Any other allergies to drugs/medications? _____

10. WOMEN ONLY: Are you pregnant or think you may be pregnant? _____ Nursing? _____Taking birth control pills? _____

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 (braces)?	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 instruction for brushing and flossing?	YES NO
14. Do you feel like you have bad breathe?	YES NO
15. Do you feel like you have any cavities?	YES NO

Financial Policy

Patients without dental insurance are expected to pay in full at the time services are rendered unless prior arrangements have been made.

Patients with dental insurance, understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Our office will prepare insurance forms, submit claims to insurance companies, and assist in the adjudication of claims. To help determine your estimated co-payment for necessary treatment we may request a pre-determination of benefits. Any estimate co-payment that is received as a result of a pre-determination or given verbally by office assignee is not a guarantee of insurance payment; it is subject to plan maximums, usage and limitations. Emergency services do not allow us time to request a pre-determination of benefits and must be paid for at the time services are rendered.

Please remember, insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is the responsible party/patient's responsibility to pay any deductible, co-insurance or any other balance not paid for by your insurance company. It is the patient or subscriber's responsibility to know the insurance benefits including, but not limited to: yearly maximum, amount used to date, and treatments covered/not covered. We are happy to review your benefits with you if you have questions.

Patients with or without dental insurance as a condition of treatment by this office, payment is expected on the day of service. Any financial arrangements must be made in advance. Please be advised that any balance on account that is over 60 days will be charged a finance charge of 15% annually (1.5% monthly). Accounts that remain delinquent may be turned over for collection action with our attorney or collection agency.

BROKEN APPOINTMENTS: We reserve your appointment time just for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **48 hour notice**, to avoid a **$35 late cancellation fee**.

Acknowledgement and Agreement

I grant my permission to the doctor or office assignee, to telephone me at home, cell or at my work to personally discuss matters related to this form and/or my care.

If insured, my signature on this form also serves as a Signature on File for my dental insurance. I understand that by signing below I authorize Quivira Park Family Dentistry to release information to my insurance(s) and act as my agent to obtain payment from my insurance company(s). I authorize payment from my insurance(s) directly to Quivira Park Family Dentistry, although I understand that I am fully responsible for my bill. I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Print name of financially responsible party Signature of financially responsible party

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

Notice of Privacy Practice

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

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: Quivira Park Family Dentistry
Privacy Officer: Michelle Olson DDS
Phone 913-955-2300
Address: 11740 W 135th St. Overland Park, KS 66221

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