PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE — 1

Mr Mrs Miss Ms
NAME

SPOUSE

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE | AGE | MALE | FEMALE

MARRIED | SINGLE | DIVORCED | WIDOWED

SOCIAL SECURITY NO.

DATE

NAME

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE | AGE | MALE | FEMALE

SCHOOL | GRADE

SOCIAL SECURITY NO.

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO.

DENTAL INSURANCE — 2

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYEE

DATE OF BIRTH | DATE EMPLOYED

UNION OR LOCAL NO.

EMPLOYER

EMPLOYEE SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO

EMPLOYEE

DATE OF BIRTH | DATE EMPLOYED

UNION OR LOCAL NO.

EMPLOYER

EMPLOYEE SOCIAL SECURITY NO.

GETTING TO KNOW YOU — 3

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME | RELATIONSHIP

REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

ACCOUNT INFORMATION — 4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY | STATE | ZIP

PHONE NO.

YOU

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS PHONE NO. | EXT.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS PHONE NO. | EXT.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Steven C. Mingos & Associates, L.L.C.
4746 Belleview
Kansas City, MO 64112
816-531-8740

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ITEM 070-5962 25950 © MAY 2002

Name _____ Address _____

Email _____ City _____ State _____ Zip _____

Home# _____ Work# _____ Cell# _____

1. Are you currently, or have you been under the care of a physician or hospitalized in the past 2 years? ..... YES NO

   If so, for what reason? _____

   Physician's Name _____ Telephone _____

2. Have you taken any medication or drugs in the past 2 years? ..... YES NO

3. Are you now taking any medications, drugs, or pills (including birth control, aspirin, herbal medicine, or dietary supplements, etc.)?..... YES NO

   If yes, please list: _____

4. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO

   If yes, please list: _____

5. Have you ever had an allergic reaction to latex? ..... YES NO

6. Have you ever taken prescription medication for weight reduction (diet pills)? please list: _____ YES NO

7. Have you ever taken Fosamax, Actonel, Boniva, Didronel, Skelid or any other medication for osteoporosis or other bone conditions?... YES NO

8. Indicate which of the following you have had or have at present.

   Please mark Y (yes) or N (no) to all of the following:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies or Hives
☐	☐	Anemia
☐	☐	Angina Pectoris/Chest Pains
☐	☐	Arthritis
☐	☐	Artificial Bones/Joint Replacement
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer - Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A (infectious)
☐	☐	Hepatitis B (serum)
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse/Heart Murmur
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice
☐	☐	Pain in Jaw Joints
☐	☐	Special Diet

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other _____

_____

9. Do you have or have you had a disease, condition, problem, or surgery not listed? please list: _____ YES NO

10. Do you smoke or use tobacco? ..... YES NO

If female, please answer the following:

Are you taking birth control pills? ..... YES NO Are you nursing? ..... YES NO

Are you pregnant? ..... YES NO If yes, what month _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature **X** _____ Date _____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the responsibility for payment of Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made; I further understand that a time charge of $5.00 or 1.5% per month (18% annual) financing charge, whichever is greater, will be added to my account for late payment. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature **X** _____ Date _____ Witness _____

Parent or Responsible Part **X** _____ _____ Relationship to Patient _____

Patient Survey

Date:_____

We are always working toward providing the best possible patient care. Periodically, we send out a survey to measure what kind of job we are doing and would like to hear back from you.

NAME:_____

E-MAIL ADDRESS:_____

Please print e-mail address clearly

Appointment Reminders

Our office wants to communicate with you the way you prefer. How do you want to receive appointment reminders? Please check all that you prefer.

☼ **E-MAIL ADDRESS:**_____

Please print e-mail address clearly

☼ **Text** _____

Preferred cell phone #

☼ **Telephone – please check one of the following:**

- ☼ **Personalize phone call**
- ☼ **Automated phone call**

PLEASE NOTE: When you receive an automated phone call from our office please listen to the prompts at the end of the message and CONFIRM the appointment by pressing the number 1 on your phone.

Date:_____

NAME:_____

Over the last few months we have conducted a survey and have found that our patients prefer to hear from us via email or text rather than calling.

Our office wants to communicate with you the way you prefer.

Please check your preference.

☼ **E-MAIL ADDRESS:**_____

Please print e-mail address clearly

☼ **Text** _____

Preferred cell phone #

☼ **Telephone**

Please check one of the following:

☼ **Personalized phone call**

☼ **Automated phone call**

FINANCIAL POLICY

Steven C. Mingos Dental Office
816-531-8740

Thank you for choosing us as your dental health care provider. We look forward to assisting you in attaining optimum oral health. Your doctor may request X-rays, study models, photographs and/or other diagnostic aids to provide you with a thorough diagnosis of your dental needs.

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment. All patients must also complete our Patient Information Form as well as your insurance form, if required by your plan, before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE unless other financial arrangements have been made in advance. We accept cash, check, Master Card, Visa, American Express and Discover cards. Other financial services are available through various companies, and for treatment plans of $1500.00 or more through **Dental Fee Plan.**

A monthly billing fee of 1.5% or $5.00, whichever is greater, will be added to all accounts that remain unpaid after 60 days. If it becomes necessary to use other means for collecting payment, the patient is responsible for any and all costs, fees, and attorney fees incurred.

Regarding Insurance

Our office requires that you pay your deductible and co-payment, if applicable, at the time of service. While every effort will be made to maximize your insurance benefits, ***the balance is your responsibility, whether your insurance company pays or not.*** If your insurance company has not paid your claim within 60 days, the balance will be automatically billed to you. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under ***your*** policy.

We will file insurance claims for you if you bring all insurance information and a **completed** insurance claim form, if required by your plan. **Information regarding insurance benefits is the responsibility of the patient**. Estimates given by our office are **not a guarantee of benefits.** We cannot be held responsible for the benefits paid (or not paid) by your insurance company.

Emergency Care

All emergency care patients are expected to remit payment at the end of the appointment.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please have the courtesy to give us a least 48 hours notice so that we may help serve other patients wanting treatment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read this Financial Policy, and I understand and agree to this Financial Policy.

X_____ Date_____

Patient/or Responsible Party

White: Office Copy Yellow: Patient Copy