Willits & Woltkamp Family and Cosmetic Dentistry

Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form. All of this information is completely confidential.

Patient Information

Full Patient Name _____ Preferred Name _____
First Middle Initial Last

Home Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Work Phone _____

E-mail Address _____ Cell Phone _____

Sex: Male Female Birth date _____ Single – Married – Widowed – Separated – Divorced

Patient Social Security # _____ Patient Employer & Occupation _____

Spouse's Name _____ Spouse's Employer & Occupation _____

Emergency contact name & phone number _____

How did you hear about our office? _____

Responsible Party Information

Person Financially Responsible _____ Relation to patient _____

Home Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Work Phone _____

Birth Date _____ SS# _____ Employer _____

Dental Insurance Information

Is patient covered by dental insurance? Yes / No (if yes, please complete the following:)

Policy Holder Name _____ Relation to patient _____

Home Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Work Phone _____

Birth Date _____ SS# _____ Employer _____

Insurance Company _____ Group # _____ Subscriber ID# _____

Is patient covered by additional dental insurance? Yes / No (if yes, please complete the following:)

Policy Holder Name _____ Relation to patient _____

Home Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Work Phone _____

Birth Date _____ SS# _____ Employed by _____

Insurance Company _____ Group # _____ Subscriber ID# _____

INSURANCE AUTHORIZATION & FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible for all charges whether or not paid by insurance. I assign all insurance benefits directly to the doctor otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Signature (Parent/Guardian if under age 18) Relationship (if patient is under age 18) Date

Please complete both sides of this form

Medical History

Name_____

Physician's Name _____ Phone _____ Date of Last Visit_____

Circle Yes or No (Y or N) if you have ever had any of the following:

Y--N AIDS or HIV positive
Y--N Acid Reflux/ G.E.R.D
Y--N Arthritis, Type:_____
Y--N Artificial joints
Y--N Asthma
Y--N Cancer
Y--N Chemical Dependency
Y--N Diabetes, Type:_____
Y--N Eating disorder
Y--N Epilepsy
Y--N Excessive bleeding

Y--N Glaucoma
Y--N Hepatitis, Type:_____
Y--N Kidney problems
Y--N Liver problems or Jaundice
Y--N Lung or breathing problems
Y--N Sinus trouble
Y--N Smoking/chewing tobacco
Y--N Stroke
Y--N Swollen neck glands
Y--N Thyroid problems
Y--N Tuberculosis

Heart Problems
Y--N Low blood pressure
Y--N High blood pressure
Y--N Pacemaker
Y--N Artificial valves
Y--N Infective (Bacterial) Endocarditis
Y--N Congential heart defects
Y--N Heart Surgeries
Y--N Other_____

Y--N Serious illnesses/hospitalizations
Y--N Currently under a physician's care
Y--N Antibiotics for dental treatment

Give details of the above 'Yes' items_____

_____

_____

Women:
Are you pregnant?_____ Due when?_____
Are you nursing?_____

ALLERGIES Circle if you are allergic to:
Aspirin – Codeine – Latex – Local anesthetic – Penicillin – Sulfa
Other allergies:_____

MEDICATIONS: Please list medications you are currently taking and why:

_____

_____

Dental History (New Patients Only)

Circle if you have ever had any of the following:

Bad breath problem
Frequent headaches, neck aches
TMJ, jaw joint pain or treatment
Gum disease treatment

Canker sores in mouth
Cold sores on outer lips
Dental anesthetic problems

Orthodontics (braces)
Full dentures / Partial dentures
Biteguard / Nightguard

Oral surgery
Excessive gag reflex
Fear of dental care

Circle if you currently have any of the following:

Pain
Toothache
Vague ache
Swelling

Sensitivity to:
heat – cold – biting
sweets – pressure
Broken tooth or filling
Loose tooth

Dry mouth
Mouth breathing
Sores or growths in mouth
Bleeding gums
Food packing between teeth

Clicking or popping jaw
Clenching or grinding of teeth
Tired, sore or painful jaw joint
Pain around ear
Other:_____

Give details and location of the above circled items_____

_____

How often do you brush?_____ floss?_____ What type toothbrush do you use? Ultrasoft – Soft – Medium – Hard – Electric

Would you like improve the appearance of your smile?_____ How?_____

Reason for today's visit _____

Former Dentist _____ City/State _____ Phone_____

Date and reason of last dental visit _____ Date of last dental X-rays _____

What have you liked about any dental office you've been to?_____ Least?_____

TREATMENT AUTHORIZATION

I have reviewed the information on both sided of this form and it is accurate to the best of my knowledge. I authorize and give consent for the dentist and/or team of this office to perform dental services as agreed between doctor and patient and/or guardian, including the use of local anesthetic and other medication as indicated.

_____ _____ _____

Signature (Parent/Guardian if under age 18) Relationship (if patient is under age 18) Date

WILLITS & WOLTKAMP FAMILY DENTISTRY

Notice of Privacy Practices

This Notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act (HIPAA) requires all health care records be kept confidential. This federal law gives you rights to control how your health information is used. We have prepared this explanation of how we maintain the privacy of your health information and how it may be used and disclosed.

Without specific written authorization, we are only permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating or managing health care and related services by one or more health care providers.

Payment refers to obtaining reimbursement for services, confirming eligibility, billing and collection activities.

Health Care Operations include the business aspect of running our practice, such as quality assessment or training. Unless you request otherwise, we may use or disclose your personal health information to a family member, friend, personal representative or other individual only to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. Any other uses and disclosures will be made only with your written authorization, unless requested by public health, judicial, police or military organizations. You may revoke such authorization in writing at any time.

You have certain rights in regard to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed at the bottom of this notice. You have the following rights:

- To request restrictions on certain uses and disclosures of your protected health information. We are, however, not required to agree to a requested restriction.
- To request confidential communications from us, by alternate means, of your protected health information.
- To obtain a copy or your protected health information, with limited exceptions. A fee will be charged for duplication. By federal law, all original records are property of this practice.
- To request an amendment to your protected health information. We may, however, deny your request in certain situations.
- To receive an accounting of disclosures of protected health information made outside of treatment, payment or health care operations or based on your previous authorization.
- To obtain a paper copy of this Notice from us upon request, even if you have agreed to receive the Notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This Notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event that you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, contact:

Richard H. Willits, D.D.S.
Willits and Woltkamp Family Dentistry
12870 Metcalf Avenue
Overland Park, KS 66213

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, DC 20201

WILLITS & WOLTKAMP FAMILY DENTISTRY

Acknowledgment of Receipt of Privacy Practices

** You may refuse to sign this acknowledgement**

I have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Patient Name(s)

_____

Signature (please note relationship to patient if not same)

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of this Receipt of Privacy Practices, but acknowledgement could not be obtain because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify) _____
  _____
  _____