Welcome to Our Practice

This confidential information will help us prepare for your visit.

NAME _____
Mr. Mrs. Ms Rev. Dr.

I prefer to be addressed as _____

Birth date ___/___/___ SS# _____-____-_____

Address _____ PO Box _____

_____ Zip _____

❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Cell # _____ Work # _____ Ext ____

E-mail address_____

Other #_____

Employer _____

Address _____

Occupation _____ There for ___ yrs

Where and when is best to reach you? _____

Who referred you to our office? _____

Other family members seen by us _____

_____

Why have you made this dental appointment at this time?

_____

_____

Why did you leave the office of your previous dentist?

_____

_____

Spouse's Name _____

Birth date ___/___/___ Work # _____

Employer _____

Address _____

Occupation _____ There for ____yrs

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Patient Registration

First Name: _____ Last Name: _____ Middle Initial _____

Preferred Name: _____ Patient is: ____ Policy Holder ____ Responsible Party

Patient Information

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Referred by: _____

Emergency Contact: _____ Emergency Contact #: _____

Confirmation calls are done via email and text messaging. Please provide the email address and cell number you would like them sent to:

Email: _____ Cell: _____

Responsible Party (if someone other than patient)

First Name: _____ Last Name: _____ Middle Initial _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Date of Birth: _____ Age: _____ SSN# _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: __ Self __Spouse __ Dependent

Insured SS#: _____ Insured DOB: _____

Employer: _____

Employer Address: _____ City _____ State ____ Zip _____

Insurance Company: _____

Insurance Company Address: _____ City _____ State ____ Zip _____

Primary Insurance Information (if applicable)

Name of Insured: _____ Relationship to Insured: __ Self __Spouse __ Dependent

Insured SS#: _____ Insured DOB: _____

Employer: _____

Employer Address: _____ City _____ State ____ Zip _____

Insurance Company: _____

Insurance Company Address: _____ City _____ State ____ Zip _____

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Medical History (1 of 2)

Patient Name _____

Have you been under the care of a medical doctor during the past two years? YES | NO
If yes, for what? _____
Physician's Name _____Phone _____
Address _____City _____State _____Zip_____

Are you currently taking any medication, drugs, or pills? Including regular dosages of aspirin, vitamins, or other nutritional supplements? YES | NO
If yes, please list name(s) and dosage _____
Have you ever taken prescription or over the counter medications for weight loss (diet pills)? YES | NO
If yes, did you have a medical exam for heart issues? YES | NO
Have you been a patient in the hospital during the past five years? YES | NO
If yes, for what reason(s)? _____
Are you allergic to or have had difficulty with any of the following substances? Please circle all that apply:
Penicillin | Tetracycline | Latex/Metals | Aspirin | Codeine | Dental | Dental Anesthetic | Sulfa | Erythromycin | No Known Allergies
Other drug allergies: _____
Do you use more than two pillows to sleep? YES | NO
Have you lost or gained more than 10 pounds in the past year? YES | NO
Women: If pregnant, how many months? _____ Are you nursing? YES | NO Are you taking birth control pills? YES | NO

Which of the following you have had or presently have. Circle "Yes" or "No" for each item. ☐ Select NO for all

Heart Attack	Yes	No	Indwelling Catheter	Yes	No	AIDS	Yes	No
Heart Failure	Yes	No	Ulcers	Yes	No	HIV	Yes	No
Heart Murmur	Yes	No	Colitis	Yes	No	Blood Transfusion	Yes	No
Heart Palpitation	Yes	No	Hives	Yes	No	Hemophilia	Yes	No
Heart Surgery	Yes	No	Diabetes	Yes	No	Sickle Cell Disease	Yes	No
Chest Pains	Yes	No	Thyroid Disease	Yes	No	Bruise Easily	Yes	No
Congenital Heart Lesion	Yes	No	Glaucoma	Yes	No	Liver Disease	Yes	No
High/Low Blood Pressure	Yes	No	Contact Lenses	Yes	No	Yellow Jaundice	Yes	No
Headaches	Yes	No	Emphysema	Yes	No	Epilepsy	Yes	No
Mitral Valve Prolapse	Yes	No	Difficulty Breathing	Yes	No	Seizures	Yes	No
Artificial Heart Valve	Yes	No	Lung Disease	Yes	No	Fainting	Yes	No
Pacemaker	Yes	No	Shortness Of Breath	Yes	No	Nervousness	Yes	No
Arteriosclerosis	Yes	No	Tuberculosis	Yes	No	Psychiatric Care	Yes	No
Anemia	Yes	No	Asthma	Yes	No	Alcoholism	Yes	No
Anticoagulants (Blood Thinners)	Yes	No	Hay fever	Yes	No	Drug/ Alcohol Dependence	Yes	No
Disease Of Blood	Yes	No	Allergies	Yes	No	Organ Transplant	Yes	No
Bleeding Easily	Yes	No	Chronic Sinus Condition	Yes	No	Hearing Impairment	Yes	No
Rheumatic Fever	Yes	No	Sinus Trouble	Yes	No	Pain In Jaw Joints	Yes	No
Arthritis	Yes	No	Radiation Treatment	Yes	No	Chronic Fatigue Syndrome	Yes	No
Cortisone Medicine	Yes	No	Cancer (list below)	Yes	No	Lupus	Yes	No
Stroke	Yes	No	Chemotherapy	Yes	No	Scarlet Fever	Yes	No
Swelling In Ankles	Yes	No	Tumor (list below)	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Hepatitis	Yes	No	Sleep- Insomnia or Apnea	Yes	No
Kidney Problems	Yes	No	Venereal Disease	Yes	No	Fibromyalgia	Yes	No
Celiac Disease	Yes	No	Chron's Disease	Yes	No			

PLEASE TURN OVER AND COMPLETE THE ADDITIONAL INFORMATION ON BACK

Please list any cancers or tumors: _____

Do you have or have you had any disease, condition, or problem not listed? YES | NO

If yes, please list: _____

Do you exercise regularly? YES | NO

If yes, what do you enjoy doing? _____

Is your nutrition important to you? YES | NO

Please briefly describe your daily diet (proteins, fats, carbohydrates etc.): _____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication

Signature_____Date_____

Parent/Guardian Signature_____Date_____

History Review

Dentist Signature_____Date_____

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Dental History (1 of 3)

Welcome! *So that we may provide you with the best possible care*
Please complete both sides of this medical/dental history form.
All information is completely confidential.

Patient Name: _____

What is the primary reason for your visit today? _____

What questions or concerns would you like us to answer? _____

What was the date of your last dental visit? _____ Last Dental Cleaning?_____ Last X-rays?_____

Do you know what kind of X-rays you had recently (within the last year)? _____

What was done at your last dental visit? _____

Previous or referring Dentist's name: _____
Telephone #_____
Address: _____
Email: _____

Generally, how often have you had dental examinations? _____ Teeth cleaning? _____

How often do you brush your teeth? _____

How often do you floss? _____

What other dental aids do you use? (Sonic brush, special brushes, rinses, special toothpastes, toothpicks, etc.)

_____

Do you feel you have any dental problems now? Yes | No

If yes, please briefly describe, listing in order of importance:
_____

PLEASE TURN OVER AND COMPLETE THE ADDITIONAL INFORMATION ON BACK

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Dental History (2 of 3)

Are any of your teeth sensitive to:		
Hot?	Yes	No
Cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get sores or blisters of the mouth?	Yes	No
Do your gums bleed / hurt on flossing?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite or facial expression?	Yes	No
Have the spaces between your teeth changed?	Yes	No
If yes, where?		

Have you ever had:		
Orthodontic treatment?	Yes	No
If yes when?		
Oral Surgery?	Yes	No
If yes, please describe:		
Periodontal treatment?	Yes	No
If yes, please describe:		
Your teeth ground or the bite adjusted?	Yes	No
A bite plate, splint, or mouth guard?	Yes	No
A serious injury to the mouth or head injury?	Yes	No
If yes, please describe:		

Do you:		
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No
If yes, how long?		
Routinely get 7-8 hours of sleep?	Yes	No
Wake feeling rested and refreshed?	Yes	No
Fall asleep easily during the day?	Yes	No
Snore or have someone tell you that you snore?	Yes	No
Wake with a headache in the morning?	Yes	No

Have you ever experienced:		
Clench/grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening the mouth?	Yes	No
Difficulty in closing the mouth?	Yes	No
Periodontal treatment?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
A bite plate, splint, or mouth guard?	Yes	No
Sore muscles? (neck, shoulders)	Yes	No

PLEASE TURN OVER AND COMPLETE THE ADDITIONAL INFORMATION ON BACK

Have been told by someone that you struggle with breathing while you sleep Yes | No

If so, have you been diagnosed with sleep apnea? Yes | No

Are you currently using a CPAP? Yes | No

If so, are you satisfied with CPAP? Yes | No

Would you be interested in an alternative to CPAP? Yes | No

Are you satisfied with your teeth's appearance? Yes | No

If you could change something about the appearance of your teeth, what would it be?

Color____ Size____ Shape____ Position (straightness)____

Other please describe_____

On a scale of 1-10 (10 being highly important) how important is it for you to keep all your teeth the rest of your life? _____

Do you feel nervous about having dental treatment? Yes | No

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes | No

If yes, please describe: _____

Is there anything else about your past dental care or future dental treatment that you would like us to know?

_____

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TELL US ABOUT YOU….

NAME: _____

The better we understand you, the better we can serve you. In keeping with our Principles and Promises, we strongly believe you are the expert on yourself. Please indicate your preference or opinion below by rating your answers on a scale of 1-5.

1 = Strongly disagree
2 = Disagree
3 = Neutral
4 = Agree
5 = Strongly agree

	Rating 1-5
My mouth is very comfortable.	
I am satisfied with the appearance of my smile.	
I will do whatever I must to keep my teeth.	
I consider dental care a high priority.	
I believe my current state of my dental health is excellent.	
I would generally prefer long lasting solutions, which may initially cost more.	
My insurance will largely determine the extent of my care.	
I will determine the extent of my care based only on my best interests.	

Please circle all <u>CONCERNS</u> you may have about dental treatment and numerically rank from 1-5 in order of importance: 1 being the most important and 5 being the least important.

anxiety/fear ___ money/cost ___ time ___ does not seem urgent ___ pain ___ lack of trust in dentist ___
frustration ___ list any other concern(s) _____
_____

Please circle all the <u>REASONS</u> you are presently seeking dental treatment and numerically rank from 1-5 in order of importance: 1 being the most important and 5 being the least important.

Pain ___ better function ___ prevent future problems ___ cosmetics/appearance ___ health ___ guilt ___
Eliminate infection ___ List any other reason(s) below:
_____

Would you like to speak with Dr. Van Boening privately about anything? ___ Yes ___ No

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Acknowledgement of Receipt of "Patient Notice of Privacy Rights"

As our patient, under HIPAA, the new federal privacy act, you have specific privacy rights. We are required by law to attempt to obtain acknowledgement of receipt of "Patient Notice of Privacy Rights".

We are required to have a notice available for our patients detailing how medical information about you may be used and disclosed and how you can get access to this information. You have a right to review our notice before signing this acknowledgement. A copy of our "Patient Notice of Privacy Rights" is posted in our waiting room and is made available from the receptionist to each patient. The terms of our notice may change. Any change in our notice will be posted in our waiting room.

A summary of your rights includes your right to:

a. Restrict the use and disclosure of health care information (but your doctor is not required to grant this type of request)
b. Receive confidential communications in an alternate form or location
c. Inspect, copy and amend protected health information (you may be billed for the cost of copying)
d. Know about any unauthorized disclosure of protected health information
e. Have a copy of our patient privacy notice

I acknowledge the receipt of a copy of the "Notice of Privacy Practices" from James Otten Dentistry.

I, _____, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

This health information may be used to enable the persons I authorize to know and understand my condition and my consultation, for claims payment purposes, or related reasons. This authorization shall be effective until (Check one):

☐ All past, present, and future periods, OR

☐ Date or event: _____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____	_____	_____
Date	Patient Printed Name	Patient Signature

_____	_____
Patient Representative Signature (required if adult is unable to sign)	Relationship to Patient

Authorization for Release of Records

I authorize the office of:

_____

to disclose and give copies of any and all records/information. Which may include, but is not limited to the following: dental records; operative records, dental history, finding and procedures, treatment, copies of radiographs, photographs, diagnostic models and additional materials.

Mail copies to: **James Otten Dentistry**
930 Iowa, Suite One
Lawrence, KS 66044
PHONE: 785.843.6698
FAX: 785.865.5617

Or, Email copies to: info@jamesottendds.com

NAME:_____

DATE OF BIRTH: _____

SIGNATURE: _____

WITNESS:_____

DATE: _____

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James Otten Dentistry

Financial Policy

At James Otten Dentistry, we are dedicated to keeping you informed about not only your dental options, but also your financial options. Like our care, our fees are individualized to your specific needs and oral health goals, and you can always be assured that you are charged a fair fee for the excellent care provided to you. Because we do not want financial misunderstandings to compromise our relationship with you, we've created a clear and concise financial policy so that you will know exactly what to expect.

Payment is due at the time of service, and we accept the following options:

- Cash
- Check
- American Express
- Mastercard
- Visa
- Discover
- FSA (Flexible Spending Accounts)
- HSA (Health Savings Accounts)

FINANCING

We are proud to say that we also offer low, or no interest financing options through Care Credit.

INSURANCE

We will do everything we can to help you get the maximum possible benefits under your dental insurance policy, and that includes filing your claim directly with your insurer. Since your policy is a contract between you and your insurer, your benefits will be paid directly to you. You are responsible for making the full payment for your dental services.

Regardless of the payment option you choose, we will never compromise on the quality of care that we provide. Our goal is to provide you with all of your dental care options, as well as the risks and costs associated with them. From there, it is up to you to decide what level of care you want to pursue.

CANCELLATIONS

If an appointment is cancelled less than 72 hours before appointment date, or a no-show appointment, there may be a fee charged to your account.

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