MINI DENTAL IMPLANT
CENTER OF KANSAS CITY

Patient Registration

Date:

Patient:

First Middle Initial Last

Preferred Name:

Address:

City, State, Zip

Email:

Phone Number:

Work Number:

Mobile Number:

Sex: ☐ Male or ☐ Female **Date of Birth:**

Social Security Number:

Patient's Employer:

Employer's Address:

City, State, Zip

Marital Status: ☐ Married ☐ Single ☐ Divorced

Spouse's Name:

If Patient is a child, Parent's name(s):

Emergency Contact:

Emergency Contact Phone Number:

Whom may we thank for referring you?

_____

Dental Insurance Information

Person Providing Insurance:

Social Security Number:

Date of Birth: Employer:

Relationship to Patient:

Is Patient a Full Time Student?

School Attending:

Insurance Company:

Group #:

Is Patient covered by additional insurance? ☐ Yes ☐ No

Person Providing Secondary:

Social Security Number:

Relationship to Patient:

Date of Birth: Employer:

Insurance Company:

Group #:

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Esthetic Enhancement all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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.

_____

Responsible Party Signature

DENTAL HISTORY

Your current dental health is: Do your gums ever bleed?

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No - Comments:

Do you like the color of your teeth? ☐ Yes ☐ No - Comments:

Do you like the size and shape of your teeth? ☐ Yes ☐ No - Comments:

What would you change about your smile if you could?

Approximate date of your last dental visit:

Why did you leave your last dentist?

Why have you come to the dentist today?

HEALTH HISTORY

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PATIENT'S NAME_____ Date of Birth: _____

How long since you have been to a dentist? What was done at this appointment?

Did you make regular visits to the dentist before then?

How often do you brush your teeth? Do you floss?

Is another member of your family a patient at our office?

Women – Are you pregnant? ☐ Yes ☐ No If Yes, Due Date?

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Latex ☐ Sulfa ☐ Erythromycin
☐ Other – If so, please specify:

Please check if you have ever had:

Heart Disease	☐ Yes	Epilepsy	☐ Yes	Liver Disease	☐ Yes
Heart Murmur	☐ Yes	Respiratory Problems	☐ Yes	Asthma	☐ Yes
Rheumatic fever	☐ Yes	Anemia	☐ Yes	Sinus trouble	☐ Yes
Congenital heart defects	☐ Yes	Thyroid problem	☐ Yes	Cancer	☐ Yes
Abnormal Aeortic Valve	☐ Yes	Chemical dependency	☐ Yes	Stroke	☐ Yes
Mitro Valve Prolapse	☐ Yes	Artificial joints	☐ Yes	TMJ (jaw/joint pain)	☐ Yes
Artificial heart valve	☐ Yes	Excessive bleeding	☐ Yes	Radiation therapy	☐ Yes
Heart pacemaker	☐ Yes	Fainting spells	☐ Yes	Psychiatric care	☐ Yes
Pre-Med	☐ Yes	Jaundice	☐ Yes	Prosthetic implant	☐ Yes
Abnormal blood pressure	☐ Yes	Hepatitis (Type A)	☐ Yes	Bruise easily	☐ Yes
Ulcers	☐ Yes	Leukemia	☐ Yes	HIV	☐ Yes
Tuberculosis or carrier of	☐ Yes	Lung Disease	☐ Yes	AIDS	☐ Yes
Diabetes	☐ Yes	Kidney Disease	☐ Yes		
Excessive urination or thirst	☐ Yes	☐ OTHER- IF so specify:			

Do you ever experience bleeding gums when brushing or flossing?	☐ Yes	☐ No
Are you having pain or discomfort at this time?	☐ Yes	☐ No
Do you feel apprehensive about having dental treatment?	☐ Yes	☐ No
Have you ever had a bad experience in the dental office?	☐ Yes	☐ No
Have you been under the care of medical doctor during the past two years?	☐ Yes	☐ No
Are you now taking any medication, drugs, or pills?	☐ Yes	☐ No

If yes, please specify: _____

I hereby authorize Esthetic Enhancement to provide any insurance company(s), claim administrator(s), and consulting health care professionals information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

_____

Patient or Authorized Guardian's signature and Date

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Esthetic Enhancement LLC

Financial Policy

Insurance

Most insurance plans are not meant to be a "pay-all" and you will typically have a deductible and/or a co-pay for all services performed. As a courtesy, we will file insurance claims for you. We believe that 60 days is an adequate amount of time for an insurance company to make payment on a claim. Therefore, any claims more than 60 days past due will become immediately payable directly by you and collecting any payment from your insurance company will become your responsibility.

Payment Information

1. **All co-pays and deductibles are due and payable the day of your appointment**.
2. We accept cash, checks, Visa, MasterCard, Discover and American Express.
3. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts.
4. Your insurance policy is a contract between you and your insurance company. We are not a party in that contract. We file insurance as a courtesy only.
5. Accounts become past due after 90 days. We reserve the right to add a finance charge of 1.2% and a late payment fee of $5.00. The account will then be turned over to collections if the balance is not paid in full in the 90-day time frame.
6. **This office requires a minimum of 48 hours notice to cancel or reschedule all appointments. Any appointment change with less than 48 hours notice will incur a minimum $60.00 fee.**

Composite / Amalgam Downgrades

Our office is dedicated to providing the highest quality care for our patients. We use the best materials available in an effort to ensure excellent results and patient satisfaction. This includes porcelain crowns and composite (white) filling material on anterior and posterior teeth. Some insurance companies do not cover the full percentage of composite (white) fillings and porcelain crowns on posterior teeth (molars & bicuspids). After the insurance pays, you will be responsible for the remaining balance (not including any preferred provider write-offs if Dr. Marengo or Dr. Sylvester is a network provider on your plan).

I hereby acknowledge that I have read, understand and agree to the terms of this document relating to insurance coverage and payment of my bill. I understand the above paragraph and agree to the terms stated.

_____

Patient or Guardian

Esthetic Enhancement LLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR Notice of Privacy Practices before you decide whether to sign this consent, Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we may maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Dave Schloss at 913-829-9222

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient: