

# Welcome to our Practice

Thank you for trusting us with your dental care. Our goal is to provide you with the finest care possible. Would you please be kind enough to answer the following questions to assist us in treating you.

**Keystone Dentistry**  
109 Apple Valley Parkway  
Belton, MO 64012  
816-331-4200

Date \_\_\_\_\_

## ***PATIENT INFORMATION***

Responsible Party

Legal Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ E-mail address \_\_\_\_\_

Sex  M  F Marital Status  Single  Married  Divorced  Separated

Primary Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Landlord \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Financial Institution \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Person to contact in case of emergency, not living in the home \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Relationship? \_\_\_\_\_

## ***EMPLOYMENT INFORMATION***

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_

Address \_\_\_\_\_

## ***SPOUSE INFORMATION***

Responsible Party

Name \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_

E-mail Address \_\_\_\_\_

## ***FINANCIAL ACKNOWLEDGEMENT***

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. If I have insurance, co-payments and deductibles will be due at time services are rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature \_\_\_\_\_

# Insurance Information

Please Have Insurance Card Ready to Give to Office Staff to Copy - Thank you.

Patient Name \_\_\_\_\_

## **PRIMARY INSURANCE**

Policy Holder \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Group Number \_\_\_\_\_

## **SECONDARY INSURANCE**

Policy Holder \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Group Number \_\_\_\_\_

## **ASSIGNMENT OF BENEFITS**

I hereby instruct and direct my Insurance Company(ies) to pay by check made out and mailed to **Terry L. Myers, DDS, PC,**  
Or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

\_\_\_\_\_  
**C/O Terry L. Myers, DDS, PC**  
**109 Apple Valley Parkway**  
**Belton, MO 64012**

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Witness

\_\_\_\_\_  
Signature of Patient, if other than Policyholder

# Welcome to our Practice

Thank you for trusting us with your dental care. Our goal is to provide you with the finest care possible. Would you please be kind enough to answer the following questions to assist us in treating you.

**Keystone Dentistry**  
109 Apple Valley Parkway  
Belton, MO 64012  
816-331-4200

Date \_\_\_\_\_

## **MINOR PATIENT INFORMATION**

Legal Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Sex  M  F Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name of School/College \_\_\_\_\_  
Primary Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
How were you referred to our office? \_\_\_\_\_  
Who may we thank for referring you? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Person to contact in case of emergency, not living in the home \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Relationship? \_\_\_\_\_

## **PARENT/GUARDIAN INFORMATION**

Legal Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ E-mail address \_\_\_\_\_  
Marital Status  Single  Married  Divorced  Separated  
Financial Institution \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_  
Address \_\_\_\_\_  
Landlord \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## **FINANCIAL ACKNOWLEDGEMENT**

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. If I have insurance, co-payments and deductibles will be due at time services are rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Parent/Guardian Signature \_\_\_\_\_

# MEDICAL AND DENTAL HISTORY

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Because of this, we may ask you to periodically update this form. Thank you for taking the time to answer the following questions.

Reason for visit \_\_\_\_\_ Approximate date of last dental visit \_\_\_\_\_

What is your *primary* concern that you would like addressed \_\_\_\_\_

Check (✓) if you have had any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding Teeth                 | <input type="checkbox"/> Sensitivity to heat            |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Click or popping jaw          | <input type="checkbox"/> Periodontal Treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Are you under a physician's care now?  yes  no

Have you ever been hospitalized/had a major operation?  yes  no When? \_\_\_\_\_

Have you ever had a blood transfusion?  yes  no When? \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  yes  no

Do you use tobacco?  yes  no Do you use controlled substances?  yes  no

**Women:** Are you pregnant?  yes  no Nursing?  yes  no Taking birth control pills?  yes  no

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_

Check (✓) if you have, or have had, any of the following:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV                  | <input type="checkbox"/> Epilepsy/Seizures         | <input type="checkbox"/> Hemophilia             | <input type="checkbox"/> Renal Dialysis      |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis A            | <input type="checkbox"/> Rheumatic Fever*    |
| <input type="checkbox"/> Arthritis/Gout            | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Hepatitis B or C       | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Heart Valve*   | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Herpes                 | <input type="checkbox"/> Stomach Disease     |
| <input type="checkbox"/> Artificial Joint*         | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Frequent Headaches        | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Swelling of Limbs   |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur*             | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Tumors or Growths   |
| <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Pace Maker*         | <input type="checkbox"/> Radiation Treatments   |  |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Trouble/Disease     | <input type="checkbox"/> Recent Weight Loss     |  |

\*Condition may require medication

List medications you are currently taking, including vitamins, aspirin and over the counter medication: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## COSMETIC EVALUATION

Rate your smile 1 to 10 (1=I hate my smile; 10=awesome) \_\_\_\_\_ Would you like to have whiter teeth?  Yes  No

What, if anything, would you change about your smile? \_\_\_\_\_

Do you have any special occasions coming up? \_\_\_\_\_

Through state of the art technology of Cosmetic Dentistry, we have a ability to help you achieve a World-Class Smile. Using Computer Assisted Dental Imaging, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Would you like to see what YOU would look like with a new and improved smile?  Yes  No. If yes, please check off all that apply:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Lighten all front teeth    | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten Rotation   | <input type="checkbox"/> Eliminate dark/stained fillings |
| <input type="checkbox"/> Lighten single tooth       | <input type="checkbox"/> Lengthen            | <input type="checkbox"/> Straighten Angulation | <input type="checkbox"/> Reduce gum showing in smile     |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Shorten             | <input type="checkbox"/> Eliminate Crowding    | <input type="checkbox"/> Repair uneven edges             |

Any other concerns you may have? \_\_\_\_\_

\_\_\_\_\_