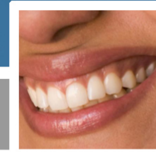
North Kansas City Dental Group
2000 Swift St.
North Kansas City MO 64116
(816)471-2911
doctor@drbusch.com
www.drbusch.com



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. ______
FOR OFFICE USE ONLY

Patient Name: ______ Last ______ First ______ MI ______ Preferred Name

Title: ______ Mr/Ms/Mrs/etc Gender: ○ Male ○ Female Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date: ______ Prev. Visit: ______ Email Address: ______

Phone: ______ Home ______ Work ______ Ext ______ Mobile Best time to call: ______

Address: ______ ______
______ City ______ State ______ Zip Code

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Morning ☐ Afternoon
☐ Any time

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper
☐ School ☐ Work ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

______

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ Last _____ First _____ MI _____ Preferred Name

Title: _____ Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ Home _____ Work _____ Ext _____ Mobile Best time to call: _____

Address: _____ _____

_____ City _____ State _____ Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ City _____ State _____ Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: ____________ ____________ ____
Last First MI

Insured's Birth Date: ____________ ID #. ____________ Group #. ____________

Insured's Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Insured's Employer Name: ____________

Employer Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____________

Insurance Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Primary Medical Insurance:

Name of Insured: ____________ ____________ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____________

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: ____________ ____________ ____
Last First MI

Insured's Birth Date: ____________ ID #. ____________ Group #. ____________

Insured's Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Insured's Employer Name: ____________

Employer Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ____________

Insurance Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Secondary Medical Insurance:

Name of Insured: ____________ ____________ ____
Last First MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ____________

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Medical & Dental History Questionnaire

Please indicate if you have experienced any of the following:

- Abnormal Bleeding
- Alcohol Abuse
- Allergies
- Anemia
- Arthritis
- Artificial Joints
- Artificial Pins
- Artificial Valves
- Asthma
- Blood Disorder
- Blood Tranfusion
- Cancer
- Chemotherapy
- Chicken Pox
- Colitis
- Diabetes
- Difficulty Breathing
- Dizziness
- Drug Abuse
- Emphysema
- Epilepsy
- Fainting
- Genital Herpes
- Glaucoma
- Hay Fever
- Headaches
- Heart Attack
- Heart Defect
- Heart Murmur
- Heart Surgery
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- High Cholesterol
- HIV+/AIDS
- Hospitalized
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Lupus
- Mitral Valve Prolaps
- Oral Herpes
- Osteoporosis/Paget's
- Pacemaker
- Persistent Cough
- Psych. Problems
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Scarlet Fever
- Seizures
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Steroid Therapy
- Stroke
- Thyroid Problems
- Tonsillitis
- Tuberculosis (TB)
- Ulcers
- Venereal Disease

Would you consider yourself to be in fairly good health?

Yes No

Within the past year or your last dental visit, have there been any changes in your general health?

Yes No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's Name, Address, & Phone Number:

Please mark any of the following to indicate YES in response to the question:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you require the use of corrective lenses(contacts or glasses)?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

Do you have any other health issues or drug allergies? Allergies of any kind?

What is the reason for your dental visit today?

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When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's Name, Address, & Phone Number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do your gums bleed when brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?
- ☐ Does your jaw pop or click when you open causing pain?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within 15 days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

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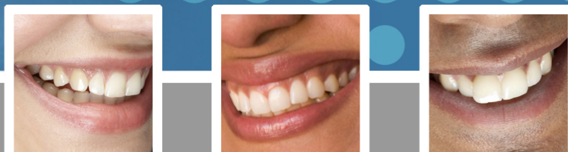

Authorization

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and may be billed for this remaining balance. I consent and agree to be financially reponsible for payment of all services rendered on my behalf of my dependents (if any).

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist of dental practice to be applied directly to any outstanding balance on my account.

I, the undersigned patient, hereby authorize the undersigned provider/staff to perform any necessary dental services. I understand before any treatment all options will be discussed. I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I give my consent for the administration of any medication that may be required as a life-saving measure.I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator/or computer translation who has explained the information in my native tongue. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: ______________________________ Date: __________

Relationship to Patient:

____