Welcome to our office! We are honored you have placed your confidence in us to take care of you and/or your family. To assist us serving you, please complete the following forms. If there are ever any changes in your health, please inform us.

Personal & Contact Information

All information is kept strictly confidential

Patient Name (First, MI, Last,): ____ Date: ___________

Gender (please circle): Male / Female Marital Status (please circle): S M W D Sep Child

Social Security Number: _________________ Birthday: __________ Driver's License#: ______________

Home Address (Street, City, State, Zip): ____

Spouse or Parent's Name: ________________________ Responsible Party: _____________________

Responsible Party's Address: ____

Responsible Party's Relationship to patient: ____

(For Minors) Are You the Legal Guardian? □**YES** □**NO** If not who is: ______________________________

Patient's (or parent's) Occupation: _______________________ Employer: __________________________

Cell Phone number: _________________________ Home Phone Number: __________________________

Business Phone Number: __________________________you may / may not call this number (please circle)

Business Address (Street, City, State, Zip): ____

Personal Email Address: ____

Secondary Email Address: ____

Spouses Occupation: ___________________________ Employer: __________________________

Business Address (Street, City, State, Zip): ____

Emergency Contact: __________________________________ Phone: ___________________________

Address: ____ Relationship: ___________

How Did You Hear About Us?

□ Through a friend or family member: ____

□ My insurance □ Google □ Yellow Pages □ TV □ Flier

□ Online search □ Facebook □ Radio □ Newsletter □ Share-a-Smile Card

□ Other: ____

Insurance Information:

Primary Dental Insurance:

Insurance Company: ______________________________ Toll Free Number: ______________________________
Group Number: ___________________________ ID Number (may be SSN): _______________________________
If you are not the subscriber on the plan:
Your relationship to the subscriber: ____
Subscriber Name: ____
Subscriber SSN: _____________________________ Subscriber Birthday: ______________________
Employer: ____

Secondary Dental Insurance:

Insurance Company: ______________________________ Toll Free Number: ______________________________
Group Number: ___________________________ ID Number (may be SSN): _______________________________
If you are not the subscriber on the plan:
Your relationship to the subscriber: ____
Subscriber Name: ____
Subscriber SSN: _____________________________ Subscriber Birthday: ______________________
Employer: ____

Medical Insurance:

Insurance Company: ______________________________ Toll Free Number: ______________________________
Group Number: ___________________________ ID Number (may be SSN): _______________________________
If you are not the subscriber on the plan:
Your relationship to the subscriber: ____
Subscriber Name: ____
Subscriber SSN: _____________________________ Subscriber Birthday: ______________________
Employer: ____

****Some procedures may qualify for reimbursement by your medical insurance. In these instances, we will bill your medical insurance first and your dental insurance secondarily if medical provides no payment.**

Please remember that insurance is a method of reimbursing patients for fees paid to the office, and is not a substitute for payment. I understand that I am responsible for any amount not covered by my insurance. I hereby authorize release of information, and I assign benefits to the dentist for services rendered.

Signature: ____ Date: ____________________________

Medical History

Is your general health good? □**YES** □**NO** If NO, please explain: ______________________________________
____

Has there been a change in your health in the last year? □**YES** □**NO** If YES, please explain: _______________
____

Physician's Name: ____________________ Phone Number: _________________ Receiving Care? □**YES** □**NO**
If "YES" Please explain: ____
____

Have you ever had or do you currently have any of the following conditions?

Yes	No		Yes	No	
□	□	Bleeding Problems	□	□	High Blood Pressure
□	□	Heart Murmur	□	□	Stroke
□	□	Breathing / Lung Problems	□	□	HIV / AIDS
□	□	Chemotherapy or Radiation	□	□	Joint Replacement
□	□	Diabetes	□	□	Organ Transplant
□	□	Heart Disease	□	□	Snoring / Sleep Apnea
□	□	Hepatitis	□	□	Rheumatic Fever / Heart Disease
□	□	Eating Disorders	□	□	Chemical Dependency / Alcoholism
□	□	Psychiatric Treatment	□	□	Epilepsy / Seizures / Fainting
□	□	Do you use tobacco? If YES, in what form and how much? __________________________________			

Have you ever taken a Bisphosphonate (Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, Skelid) or osteoclast inhibitor drug (Prolia)? □**Yes** □**NO** If YES, how long ago and how taken? ______________________

Are you allergic or have you reacted adversely to any of the following? (please circle): Penicillin / Latex / Sulfa Drugs / Local anesthetic (Novocain) / Other Allergies: ____

For Female Patients

Yes	No		Yes	No	
□	□	Are you pregnant?	□	□	Are you nursing?
□	□	Are you currently taking oral contraceptives (antibiotics may decrease effectiveness)			

Any other medical conditions, please describe: ____
____
____

Please list drugs and supplements you are taking right now and state for what condition? (include prescription, over the counter, and recreational) *example: Prilosec for acid reflux*: ___________________________________
____
____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potential medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician. I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (parent/guardian)____**Date**_____________________________________

Dental History

Has a physician or dentist ever recommended you take antibiotics before dental treatment? □**YES** □**NO** If YES, please explain: ____

How can we help you today? ____
____

Who was your last dentist? ______________________________ Location? __________________________
Why did you decide to change dentists? ____
When was the last time you saw a dentist? __________ X-rays? _________ Professional Cleaning? _________
Have you ever had an unpleasant dental experience?) □**YES** □**NO** If YES, please describe, we want to make sure it doesn't happen again! ____
____

How is your current dental health? □Good □Average □Needs improvement □Not sure
Do your gums bleed when you brush or floss? □Never □Sometimes □Almost every time
Do you feel you will eventually wear artificial dentures? □YES □NO
Are you concerned about the finances required to achieve excellent dental health? □YES □NO
Any jaw problems? □Pain □Clicking/Joint Noise □Difficulty opening/closing □History of TMD □NONE
Do you Grind or Clench? □YES □NO Do you get frequent migraines/headaches? □YES □NO
Have you been diagnosed with Sleep Apnea? □YES □NO If YES, do you wear a CPAP? □YES □NO
If you wear a CPAP, are you comfortable with it? □YES □NO
Are you interested in cosmetic options? □YES □NO If yes, please describe: __________________________
____

Are your teeth sensitive to (please circle) **cold** / **hot** / **sweets** / **biting**? If so, please explain (where/when): ____
____

Does dental treatment make you nervous? □YES □NO Are you interested in our relaxation methods to ease dental anxiety or get more work done in fewer appointments such as (please circle) Nitrous Oxide (laughing gas) or Anxiolysis (oral sedatives with nitrous)

Any other concerns? ____
____
____
____
____

Office Policies

5 Second Survey
After every visit, you'll receive a short survey via email about it. In addition, we have opinion cards in the office for you to fill out. We pay *very* close attention to these responses. They are used to recognize employees for excellent performance and identify any area where we can improve our service. Please be perfectly honest with the surveys, we really want to hear how your visit went with us because we're continually looking for ways to improve our patient's experience.

Video and Audio Recording
Video and audio recording devices are used throughout the office to ensure a high-quality experience for all our patients. These recordings may be used for training purposes.

24-Hour Cancellation Policy
When we reserve time for your appointment, we make room in our schedule so that we may devote our time and focus our efforts on serving your needs. This special time slot has been reserved only for you, as we do not double-book our patients. If you are unable to keep your appointment, we ask you to kindly give us 48 business hours' notice. There is a minimum $65 charge for reserved appointments broken or changed without 24 hours' notice; this includes calling to reschedule on the day of your appointment. This is a minimum fee and larger fees may be assessed up to the full cost of your appointment. If you are late to your appointment and unable to be seen because there is not enough time to complete your procedure, this will be considered a broken appointment and also charged the fee.

Mobile Phone Policy
We request that you **turn off** or silence and **put away** your phone while in the clinic for the courtesy to and privacy of others. In accordance to federal privacy laws, **pictures are not allowed in the office and may result in legal confiscation of your phone!** Please understand we are following federal laws that are continuously becoming stricter and more enforced. In addition, we work hard and do our best to stay on schedule. Phone use can disrupt the flow of the office, resulting in you or other patients having to wait. We understand emergency situations; and if you have a call you need to take, please inform our team members when you enter the operatory.

Help Maintain a Clean Environment
We are very diligent, focused, and work hard to maintain a clean environment for all our patients and team members. We ask that you please do not put your fingers in your or your children's mouth(s) while visiting our office and if you must, please wash your hands immediately afterwards.

Prescription Drugs
Research has shown that non-narcotic drugs are as effective in controlling dental pain as narcotic/opioid drugs (hydrocodone, oxycodone, etc.). In addition, there continues to be growing evidence that non-narcotic drugs may be MORE effective in controlling dental pain. Due to this evidence and to the growing problem of prescription drug overdoses, **our office avoids prescribing and does not store any narcotic drugs**. We have excellent success in controlling our patients' dental discomfort without the use of narcotics. In addition, our office voluntarily participates in the online Prescription Monitoring Program known as K-TRACS (Kansas Tracking & Reporting of Controlled Substances) which collects prescription data on controlled substances.

Reward Programs
We are constantly running contests and offering rewards for our patients such as our Good Deed Contest, Halloween Candy Buyback, Facebook giveaways, and many more. Please check out our website at www.DentistryByDesignKS.com and like us on Facebook (facebook.com/DentistryByDesignKS) to keep abreast of our various programs and get yourself a chance to win!

I understand these policies and don't have any questions (if you do, please ask!):

____________________________________ _______________________

Your Signature Date

Financial & Privacy Policies

You are responsible for the total fee for services performed at this office. Cash, checks, and all major credit cards are accepted as payment for services.

If you have insurance, we will provide an **estimate** of what we think your insurance company will **probably** pay and prepare financial arrangements with you for your portion. We do this for transparency and as a courtesy for you; however, **you** are responsible for understanding and knowing your insurance policy. Most of our patients prefer our automatic four monthly credit card payments which we can set up for you. This makes it very convenient for our patients, because they can come and go as they please without worrying about having to make a payment, similar to a fast checkout at a hotel. We can only set up one payment plan at a time.

If you have insurance, we will bill your insurance for all procedures completed on your behalf. Cosmetic and other procedures not paid by insurance may not be billed to insurance.

If the insurance company pays more than we expected, you will have a credit on your account. You may keep it on your account or we can refund it to you. All outstanding insurance claims must be received before we may issue any refunds.

If the insurance company pays less than we expected or not at all, you are responsible for the difference between what you have already paid and your total fee. We will try to arrange payment from your insurance company for a maximum of 45 days. After 45 days, you are responsible for any balance on your account, regardless of whether your insurance company has paid us or not. If we receive payment after 45 days from your insurance company, it will be applied to your account, and you will have a credit, which you can keep on the account or we can refund you.

After 90 days from the date of service, any unpaid balance may be taken to small claims court and/or will be turned over to a collection agency. This is our standard policy for all delinquent accounts. Once an account is sent to collections, you must pay the collection agency. You will no longer be able to pay us directly for the balance.

All account balances 30 days past due are subject to a finance charge.

All returned checks and credit cards declined for insufficient fund are subject to a $30.00 processing fee.

In accordance with HIPAA, I understand that I am giving my full permission to this office to use and disclose my protected health information in order to carry out treatment, payment activities, and healthcare operations. I understand I have the right to revoke permission. I understand that my insurance company will send payment directly to the office unless prior arrangements have been made.

____ ___________________________

Your Signature Date

Bret B Gilsdorf, DDS, LLC
1110 Westport Drive, Manhattan, KS 66502
P: 785-539-2314 F: 785-539-1121

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Dentistry By Design's Notice of Privacy Practices, which has an effective date of 09/23/2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_______________________________________ ____________________
Signature of Patient or Patient's Representative Date

____
Print Name

____
Relationship to Patient (If not signed by the Patient)

Radiograph Policy

I, _______________________, understand that radiographs will be required to properly.
Responsible Party's Name
diagnose any and all treatment. I have been given the opportunity to provide previous x-rays. I understand if previous x-rays are not diagnostic then new x-rays will be taken. I agree to pay the difference if insurance does not cover.

X
____
Responsible Party's Signature

Date_______________________