Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions, we'll be glad to help. (Please print).

Welcome!

Liberty Park Dental ● 1508 NE 96th Street, Suite A, Liberty, MO 64068 ●(816) 415-8080

PATIENT INFORMATION

Name: _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: _____

Address:_____ Occupation: _____ [ ] Male [ ] Female

City: _____ State: _____ Zip: _____ Home #: (___) ___-_____

Employer: _____ Work #: (___) ___-_____Ext:___

Email: _____ Cell #: (___) ___-_____

DOB: _____ SSN: _____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated

Spouse's Name: _____
First MI Last

Spouse Occupation: _____

Is patient a full time student? [ ] No [ ] Yes: Name of School: _____

RESPONSIBILITY PARTY (if different than patient)

Name: _____
First MI Last

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

Home #: (___) ___-_____Work #: (___) ___-_____Ext:____ Cell #: (___) ___-_____

DOB: ___/____/_____ SSN: _____ Relationship: _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE:

Subscriber's Name: _____ Relationship to patient: _____

DOB: ___/____/_____ Subscriber's SSN: _____

Insurance Company: _____ Policy #: _____ Group #:_____

SECONDARY DENTAL INSURANCE:

Subscriber's Name: _____ Relationship to patient: _____

DOB: ___/____/_____ Subscriber's SSN: _____

Insurance Company: _____ Policy #: _____ Group #:_____

Primary Physician's Name: _____ Physician's Phone Number: _____

Are you under the care of other physicians? If so, please list:

Physician Phone Number Reason

_____

_____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Liberty Park Dental to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Liberty Park Dental to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Liberty Park Dental choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risks and consent to their use as deemed appropriate by Liberty Park Dental. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANICAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental and medical insurance (if any). I further consent to and agree to pay a 1.5 % finance charge (18% annually) that may be applied to any balance over 30 days as well as any fees deemed necessary to collect my account. I authorize Liberty Park Dental, LLC and staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, as well as handle any necessary claim appeal(s). Lastly, I acknowledge that if I cancel an appointment with less than 24 hour cancelation notice, I may be charged a fee based upon the amount of time I was scheduled.

Consent (adult):

Name of Patient: _____ Signature of Patient: _____ Date: _____

*** Please Note: Your electronic signature above constitutes your understanding as if this were signed by you in writing.

Consent (for a minor child):

Name of Patient: _____ Signature of Patient: _____ Date: _____

*** Please Note: Your electronic signature above constitutes your understanding as if this were signed by you in writing.

Liberty Park Dental Medical History-Updated 1/6/2020

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Have you been advised to take antibiotics before dental treatment?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No	Acid Reflux ◯ Yes ◯ No	Bleeding Gums ◯ Yes ◯ No	Dry Mouth ◯ Yes ◯ No
Jaw Problems (TMJ) ◯ Yes ◯ No	Jaw Clicking ◯ Yes ◯ No	Jaw Pain ◯ Yes ◯ No	Orthodontics/Invisalign ◯ Yes ◯ No
Periodontal Disease ◯ Yes ◯ No	Teeth Clenching ◯ Yes ◯ No	Teeth Grinding ◯ Yes ◯ No	Tooth Pain ◯ Yes ◯ No
Do you wear removable teeth? ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Sleep Apnea

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	◯ Yes ◯ No	
Do you often feel tired, fatigued, or sleepy during the daytime?	◯ Yes ◯ No	
Has anyone ever told you they observed you stop breathing or making gasping sounds during sleep?	◯ Yes ◯ No	
Do you have a history of or are you currently being treated for high blood pressure?	◯ Yes ◯ No	
Do you use CPAP? If yes, how often?	◯ Yes ◯ No	If yes
Are you interested in an oral appliance as an alternative to CPAP?	◯ Yes ◯ No	

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

*** Please Note: Your electronic signature above constitutes your understanding as if this were signed by you in writing.

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.
Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:
❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):
Name:_____ Relationship:_____
Name:_____ Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENT or discuss TREATMENT/HEALTH CONCERNS and/or BILLING INFORMATION** VIA: (choose all that apply)
❑ Cell Phone Text/Call
❑ Home Phone Confirmation/Message
❑ Work Phone Confirmation/Message
❑ Email
❑ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

*** Please Note: Your electronic signature above constitutes your understanding as if this were signed by you in writing.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer_____

*** Please Note: Your electronic signature above constitutes your understanding as if this were signed by you in writing.