Periodontal Care, P.A.

Healthy Gums, Healthy Heart

North Office:
5707 NW 64th Terrace
Kansas City, MO 64151
Office: 816.741.3830
Fax: 816.741.2693
periocaremo@gmail.com

Adam C. McClellan, DDS

South Office:
5000 W 95th Street, Ste 270
Prairie Village, KS 66207
Office: 913.341.4141
Fax: 913.341.4432
periocareks@gmail.com

Welcome to Our Office

Please complete the following information so that we may better serve you.

Date: ____________________________ General Dentist: ___________________________

PATIENT INFORMATION

Title: Mr. Mrs. Ms. Miss Dr. Legal Name: ____ ☐ Male ☐ Female

Preferred Name: ______________________________ Birthdate: ____________________ Marital Status: ______________

Address: ____ City: ___________________ State: ________ Zip: ____________

Home Phone: _______________________ Work Phone: _______________________ Cell Phone: ________________________

E-Mail Address: ____ Social Security #: __________-_______-__________

Employer: _______________________________________ Occupation: ___________________________

If Patient is a Minor, Give Responsible Party's Name: ____________________________________ Relationship to Pt: ____________

Pharmacy and Intersection Location: ____ Pharmacy Phone: __________________

DENTAL INSURANCE INFORMATION (not medical):

Primary DENTAL Insurance:	**Secondary DENTAL Insurance: (if applicable)**
Subscriber Name: _________________________________	Subscriber Name: _________________________________
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber ID/SSN: _______________________________	Subscriber ID/SSN: _______________________________
Subscriber Date of Birth: __________________________	Subscriber Date of Birth: __________________________
Subscriber's Employer: ____________________________	Subscriber's Employer: ____________________________
Insurance Company: _______________________________	Insurance Company: _______________________________
Group#: ____	Group#: ____

EMERGENCY NOTIFICATION INFORMATION

Primary Care Physician: ____ Phone: __________________________________

In case of an emergency, who should be notified?

Name: ____________________________________ Phone: _______________________ Relationship to Patient: ____________

Periodontal Care, P.A.
Financial Policy

The primary goal of our office is to provide you with the quality dental care you need. We will strive to make this as affordable as possible.

Please understand that your dental insurance was not created to pay for all your dental care needs. Unlike health insurance, dental insurance was created to assist with the costs of some preventative treatment needs; x-rays, simple cleanings, simple fillings, etc.… By nature of being in a periodontal office, your dental needs cannot be considered “simple”. Therefore, you should be prepared for some level of personal financial responsibility for the dental care received. We will assist you with your benefit eligibility before treatment to help calculate patient responsibility. This payment is due at the time of service.

We accept payment in the form of Cash, Check, Credit Card, and Care Credit

INSURANCE

Periodontal Care, P.A. provides insurance company billing as a *courtesy* to our patients. The patient portion of dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the plan’s limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely solely upon any information provided by Periodontal Care, P.A. staff regarding his/her remaining benefit in any such benefit period. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You as a patient are always responsible for any charges that are not covered by your insurance.

Medical Insurance

Periodontal Care, P.A. does not file medical insurance on *any* services. We are happy to provide you with the dental codes used and a form that you can fill out to file the medical claim with the help of your medical carrier.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

RESERVATION POLICY

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for surgical appointments, treatment plans over $2,000 will require a 20% down payment to reserve your treatment time.

MISSED APPOINTMENTS

General Appointments- Unless cancelled at least 24 hours in advance, our policy is to charge for missed hygiene and doctor exam appointments at the rate of $50.00 per appointment at the discretion of Periodontal Care, P.A. Please help us service you better by keeping scheduled appointments.
Surgical Appointments- Unless cancelled at least 48 hours in advance, our policy is to charge for missed surgical appointments at the rate of $250.00 per appointment at the discretion of Periodontal Care, P.A.

I have read and agree to the Financial Policy and the Cancellation Policy of Periodontal Care, P.A.

Signature of Patient or Responsible Party: ___________________________________ Date: ___________________

Health History

Patient Printed Name: ___________________________________

Oral Home Care Habits: Toothbrush: Regular or Electric   Floss: Regular/Hydrofloss/Waterpik/None   Type of Mouth rinse: ____________

1. Date of last checkup/physical: ________________   Date of last dental cleaning: ___________   Frequency: every 3 4 6 months

2. Previous Periodontal Treatment/Gum Surgery? ☐ YES ☐ NO If so, Date: ______________ Family History of Gum Disease? ☐ YES ☐ NO

3. Have you been in the hospital in the past 2 years? ☐ YES ☐ NO Explain: ____

4. Current or Former smoker? ☐YES ☐ NO Packs/day? _________ For how long? ___________ Quit Date: ___________

5. Current or Family History of Diabetes? ☐ YES ☐ NO Self/Mother/Father Type I or Type 2 Current A1C: ____________

6. Current or Previous treatment for Osteoporosis/Bone cancer? ☐ YES ☐ NO Oral/IV treatment with: ☐Boniva ☐Fosamax ☐Zometa

   If YES, which medication and why? ____

7. Currently taking or previous treatment with immunosuppressive therapy? ☐ YES ☐ NO Use of Biologics such as Enbrel? ☐YES ☐ NO

   If YES, which medications and why? ____

8. Do you have any prosthetic devices (e.g. heart valve or stent, artificial joint, implant, pacemaker, etc.)? ☐YES ☐ NO

9. Do you require a Pre-Medication of antibiotics before dental procedures as ordered by a physician? ☐ YES ☐ NO

   If YES, which antibiotic do you currently take? ____

10. FEMALES: Are you pregnant or thinking about becoming pregnant? ☐ YES ☐ NO

11. Are you allergic or sensitive to any medicine, dental anesthetic or latex products? ☐ YES ☐ NO

   If YES, to what? ____

Prescription Medications or over-the-counter medications: **(attach separate sheet if needed)**

Medication and Dosage:	Why Taking:
1.	
2.	
3.	
4.	

Medication and Dosage (Cont'd):	Why Taking:
5.	
6.	
7.	
8.	

12. Do you have now ***or have you ever had*** any of the following diseases or medical conditions? (please check if YES)

☐ ⇧ Urination
☐ ⇧ Thirst
☐ Allergies
☐ Aneurysm
☐ Arthritis
☐ Asthma
☐ Bisphosphonate Drugs/Osteoporosis
☐ Blood Transfusion
☐ Cancer/malignancies
☐ Chemo/radiation Therapy
☐ Chest Pain/ Angina Pectoris
☐ Colitis/Crohn's/Intestinal Problems
☐ Chronic Bronchitis
☐ Chronic Tiredness/ Fatigue
☐ Congenital Heart Defect
☐ Congestive Heart Failure
☐ Coronary Artery Disease /Bypass
☐ Diabetes / High Blood Sugar
☐ Difficult to Lie Back in Dental Chair
☐ Drug Addiction / Alcoholism
☐ Emphysema
☐ Eye/Vision Disorders
☐ Fainting/ Dizziness
☐ Hearing Loss/ Ear Problems
☐ Heart Disease/ Heart Attack/ MI
☐ Heart Murmur
☐ Heart Surgery /Angioplasty/ Stent
☐ Hemophilia/ Prolonged Bleeding
☐ Hepatitis A, B, or C / Liver Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ High Fear of Dentistry
☐ HIV+ / AIDS
☐ Kidney, Bladder Problems/ Dialysis
☐ Mitral Valve Prolapse
☐ On a Special Diet
☐ Pacemaker
☐ Organ Transplant
☐ Palpitations/ Arrhythmia
☐ Panic Attacks/ Phobias
☐ Persistent Cough
☐ Psychiatric Treatment/ Depression
☐ Recent Weight Gain or Loss
☐ Rheumatic Fever
☐ Seizures/ Epilepsy/ Convulsions
☐ Severe Headaches / Dizziness
☐ Sexually Transmitted Disease
☐ Shortness of Breath
☐ Sinus Problems
☐ Stroke/ TIA
☐ Thyroid Problems
☐ Tuberculosis (TB)
☐ Weakness/ Tingling/ Numbness
☐ Wheezing/ Difficulty Breathing

13. Is there any additional information (disease, condition or problem not listed) we should know of? ☐ YES ☐ NO

   If Yes, Explain ____

To the best of my knowledge, the information I have given is true and correct. I understand that this will be held in confidence and it is my responsibility to inform Periodontal Care, P.A. of any future changes in my medical status.

Signature of Patient, Parent or Guardian: ____ Date: ________________________

Relationship to Patient: ☐ SELF ☐ PARENT ☐ GUARDIAN ☐ OTHER: ___________________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- Photos will often be taken of your case to be submitted for insurance purposes and occasionally used for marketing and education purposes.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

____

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ Date: _______________

Witness: ____ Date: _______________

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