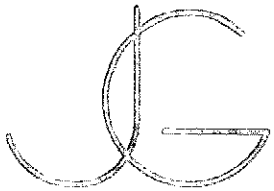

Welcome to our office!

Patient Information

Patient Name:_____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____ Birth Date: _____

Social Security #:_____ Driver's License #:_____ State:_____

Phone (Home):_____(Work):_____ Ext:_____ Best time to call:_____

E-Mail:_____ Fax:_____ Mobil/Cell:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Previous Dentist:_____ Date of Last Dental Visit: _____

Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies_____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Disease
☐ Bruise Easily
☐ Cancer
☐ Cold Sores/Fever Blisters
☐ Contact Lenses
☐ Cortisone Medication
☐ Diabetes
☐ Diet (Special/Restricted)
☐ Dizziness
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ H.I.V. Positive
☐ Head Injuries
☐ Heart (Attack, Disease, Surgery)
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ **Latex Sensitivity**
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Psychiatric/Psychological Care
☐ **Pregnancy**
Due Date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Smoke/Chew Tobacco
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ **Penicillin Allergy**
☐ Allergic/Adverse Reaction To Medication of Any Substance, Please specify: _____
_____
_____
☐ Other:_____

☐ Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:_____
☐ Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:_____
☐ Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:_____
☐ Name of Physician:_____ Phone: _____
☐ Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:_____
☐ Are you taking any medications? Purpose? Please list _____
(List additional medications on back page)

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Doctor

Cosmetic Information

Do you like the appearance of your teeth? _____

Is there anything about your smile that you do not like? _____

Would you like your teeth to be whiter? _____

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable when chewing, biting? _____

Do you have frequent headaches? _____

Do your gums ever bleed? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

Are you aware or ever been told that you clench or grind your teeth? _____

Is there anything else that you would like us to know? _____

We routinely use latex products for your safety. If you have a known sensitivity to latex products, please notify us prior to being called back to the treatment room.

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Family Member

☐ Yellow Pages ☐ Internet/website ☐ Work ☐ School ☐ Other _____

Name of person referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Driver's License #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date:_____ ID#:_____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Telephone:

_____

Consent for Services

I hereby authorize Dr. Goodman and/or staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Goodman to make a thorough diagnosis of my/my child's dental needs. Upon such diagnosis, I authorize Dr. Goodman to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and 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.

Patients who carry dental insurance understand that all dental services furnished 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 such 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 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are made.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of ninety (90) days from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by Dr. Goodman, I agree to pay the reasonable value of said services to Dr. Goodman or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 were instituted hereunder.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes and I agree to the same.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____ Date:_____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date:_____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Insurance Disclaimer
(Please read carefully)

Please note we do not accept nor participate with any DMO/HMO insurance plans, prepay plans, Medicaid or discount plans.

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental insurance plan for services. When we call on your insurance and verify benefits it is **not a guarantee of payment** by the insurance company and may vary according to your individual plan when the actual claim is submitted.

Any treatment plan that our office proposes to you is an **estimate** of what your insurance coverage will be, **it is not a guarantee**. If you want an **exact** amount/payment of benefits, then a pre determination/treatment is required. If you would like this done, you must specify to the office staff **before** any work is initiated.
(This takes 6-8 weeks _____ (Initial)

Please remember that the contract itemizing your dental benefits is between you, your employer and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of the treatment. If your insurance plan does not pay within **120 days** of treatment you must pay any outstanding balance and seek reimbursement for your dental plan. If your dental plans pays more that expected, you will receive a refund check. Also remember dental insurance plans are not designed to cover all of you dental needs.

I, _____, have chosen to allow John P. Goodman D.D.S to file my insurance and accept full responsibility for this account and for all dentistry performed upon myself and my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits. I also understand that if my insurance company does not pay within **120 days** of my date of service then I will become responsible for any outstanding balance and will need to pay promptly.

Print Name: _____ **Date:** _____

Patient Signature: _____

Staff Signature: _____

ADDITIONAL MEDICATIONS

NOTES

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I _____ have received a copy of this offices Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

For office use only

We attempted to obtain written acknowledgment of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make any significant changes in our privacy practices we will change this Notice and make the new Notice available upon request.

You may request a copy of our notice at any time. For more information about out privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES & DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your dental information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioners and provider performance, conducting training program, accreditation, certification and licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described to you

To your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (Including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on the determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your dental information for marketing communications without you written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health of safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use of disclose your health information to provide you with appointment reminders (such as voicemail messages, texts, postcards, letters or email.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a formant other than photocopies. We will us the format you request unless we cannot practically do so. (you must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $2.00 per hour for staff time to located and copy your health information and postage if you want the copies mailed to you. If you request an alternative format we will charge a cost-based fee for providing your health information in that format. If you prefer we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment and healthcare operation, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions but if we do we will abide by our agreement (except in an emergency)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handheld under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or my electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you my complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Humans Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Humans Services.

Contact Office: John P. Goodman D.D.S., L.L.C.
Telephone 816-842-5335 or 816-842-8585 Fax 816-842-2141
Email john@johngoodmandds.net
Address 2700 Clay Edwards Dr. Suite 570, North Kansas City, MO 64116
