Dear Patient,

Thank you for expressing interest in our dental office. We are grateful for having the opportunity to provide dental services for you and your family.

The new patient examination is a time that we place great value in getting to know you and to determine if any dental needs may be recommended. We allocate extra time during this visit so we may educate, in order for you to make informed decisions regarding your own health. We will not pressure you nor judge you in any way. We believe in treating others as we would want to be treated.

We employ modern technology to ensure your comfort, and we will always strive to earn your trust and confidence in our ability to provide you with our very best. I am extremely proud of my staff as they are very caring, compassionate coworkers.

If you should have any questions at any time, please feel to call upon us so we can openly discuss any concerns you may have. I look forward to meeting you and developing a professional relationship centered in knowledge, anchored by compassion and dedicated to excellence.

Sincerely,
James T. Voorhees, D.D.S.

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information:

Today's Date: ______________________________

Name: ______________________________

Preferred or Nick Name: ______________________

Male # Female

Married # Unmarried # Separated # Widowed

(If child) Mother's Name: ______________________

(If child) Father's Name: ______________________

Address/Apt#: ______________________________

City/State/Zip: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone: ______________________________

Email: ______________________________

Date of Birth: ____________________ Age:_____

Social Security #: ___________________________

Place of Employment: ______________________

Emergency Contact ________________________

Phone Number ________________________

Insurance Information:

Responsible Party: ___________________________

Relationship to Patient: ______________________

Employer: ______________________________

Insurance Company: ________________________

Date of Birth: ______________________________

Social Security #: ____________________________

Complete the Following if You Have Secondary Insurance:

Responsible Party: ___________________________

Relationship to Patient:______________________

Employer: ______________________________

Insurance Company: ________________________

Date of Birth: ______________________________

Social Security#: ____________________________

How Did You Hear About Us?

Insurance # Phone Book # Doctor Referral # A Friend

Name: ____

Reason for Today's Visit ____ Date of last dental care __________

Former Dentist ____ Date of last dental X-ray __________

How often do you: brush _______________ floss_______________ use rinses? _______________

Have you ever had previous periodontal treatment? ❑ Yes ❑ No If yes, was it surgical? ❑ Yes ❑ No

Are you satisfied with the way your teeth look? ❑ **Yes** ❑ **No**

Check (✔) if you are currently having problems with any of the following:

❑ Bad Breath	❑ Grinding Teeth	❑ Sensitivity to hot
❑ Bleeding gums	❑ Loose teeth or broken fillings	❑ Sensitivity to sweets
❑ Clicking or popping jaw	❑ Periodontal treatment	❑ Sensitivity when biting
❑ Food collection between teeth	❑ Sensitivity to cold	❑ Sores or growths in your mouth

MEDICAL HISTORY

PATIENT NAME ____________________ Birth Date ____________________

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________________
Are you on a special diet? ◯ Yes ◯ No ____________________
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ____________________

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ____________________

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 ____________________ DATE ____________________

Addendum

PATIENT NAME____________________________________ Birth Date____________________

Please check yes / no as they apply:

Grind your teeth	o Yes	o No
Clench your teeth/jaw	o Yes	o No
Bite nails	o Yes	o No
Bad breath	o Yes	o No
Clicking / popping in your jaw	o Yes	o No
Loose Teeth	o Yes	o No
Mouth breather	o Yes	o No
Bulimia / Anorexia	o Yes	o No
Sensitive to sweets	o Yes	o No
Thumb / finger sucker	o Yes	o No
Soda	o Yes	o No

If yes, how much ____________________

Cigar / Cigarette / Pipe o Yes o No
If yes, how much ____________________

Periodontal treatment o Yes o No
If yes, how long ago ____________________

Tongue thrust	o Yes	o No
Sensitivity to hot	o Yes	o No
Sensitivity to cold	o Yes	o No
Sensitivity when biting	o Yes	o No
Bleeding gums	o Yes	o No
Food collection between teeth	o Yes	o No
Broken teeth	o Yes	o No
Sore or growth (s) in your mouth	o Yes	o No
Special diet	o Yes	o No
Gum	o Yes	o No

If yes, how often ____________________

Smokeless tobacco
If yes, how much ____________________

Is there anything about your smile you would like to change?______________________________

____

____

Would you like whiter teeth?____________________

What type of toothpaste do you use?____________________ Mouthwash? ____________________

How often do you brush? ____________________ Floss?____________________

Do you have a manual or electric toothbrush? ________________

Payment Policy

We accept the following forms of payment: Cash, Credit Card or Third-Party financing through Care Credit.

We will file your insurance as a courtesy to you. ESTIMATED Co-pay is due the day of service.

We work 100% for you, **not the insurance company**. We do not compromise our standards by offering anything less than the care you deserve. As the cost of quality health has risen, most insurance reimbursements have remained relatively flat. Therefore, most dental procedures have an out- of -pocket co-pay. We do not diagnose or treat based on any insurance allowances or UCR Tables. Our fees are determined on the care, judgement and skill of the provider.

Please initial:

1. I understand payment is due on the date of service______
2. I understand I am responsible for the full fee regardless of insurance______
3. I understand the estimated co-pay is only an estimate and I owe any balance left after insurance pays________
4. I understand that it is my responsibility to inform your office of any insurance changes________

Signature:________________________________ Date:_________

I authorize James T. Voorhees, DDS to submit to my Insurance Company and I authorize my Insurance Company to pay him directly.

Signature:________________________________ Date:___________

Acknowledgement of Receipt of Notice of Privacy Practices

James T. Voorhees D.D.S.

8615 Rosehill Road * Lenexa, KS 66215

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Print Name:____

Signature:____

Date:____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be contained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

____

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