Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # ______________

SS#/SIN ______________

Date ______________

Patient Information (CONFIDENTIAL)

Name ______________ Birthdate ______________ Home Phone ______________

Address ______________ City ______________ State/Prov. ______ Zip/P.C. ______

Email ______________ Cell Phone ______________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College ______________ City ______________ State/Prov. ______ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer ______________ Work Phone ______________

Address ______________ City ______________ State/Prov. ______ Zip/P.C. ______

Spouse or Parent/Guardian's Name ______________ Employer ______________ Work Phone ______________

Whom may we thank for referring you? ______________

Person to contact in case of emergency ______________ Phone ______________

Responsible Party

Name of Person Responsible for this Account ______________ Relationship to Patient ______________

Address ______________ Home Phone ______________

Email ______________ Cell Phone ______________

Driver's License # ______________ Birthdate ______________ Financial Institution ______________

Employer ______________ Work Phone ______________ SS#/SIN ______________

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured ______________ Relationship to Patient ______________

Birthdate ______________ SS#/SIN ______________ Date Employed ______________

Name of Employer ______________ Union or Local # ______________ Work Phone ______________

Address of Employer ______________ City ______________ State/Prov. ______ Zip/P.C. ______

Insurance Company ______________ Group # ______________ Policy/ID # ______________

Ins. Co. Address ______________ City ______________ State/Prov. ______ Zip/P.C. ______

How much is your deductible? ______________ How much have you used? ______________ Max. annual benefit ______________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ______________ Relationship to Patient ______________

Birthdate ______________ SS#/SIN ______________ Date Employed ______________

Name of Employer ______________ Union or Local # ______________ Work Phone ______________

Address of Employer ______________ City ______________ State/Prov. ______ Zip/P.C. ______

Insurance Company ______________ Group # ______________ Policy/ID # ______________

Ins. Co. Address ______________ City ______________ State/Prov. ______ Zip/P.C. ______

How much is your deductible? ______________ How much have you used? ______________ Max. annual benefit ______________

Over Please

Patient Medical History

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________________		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ______________	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam ______________________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments ____

____

______________________ Signature ______________________ Date ______________________

PATTERSON OFFICE SUPPLIES 1.800.637.1140 051-1030/16790

Chart #: ____________
FOR OFFICE USE ONLY

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)

Email Address: ______________________________________

Cell Phone Number: ________________________

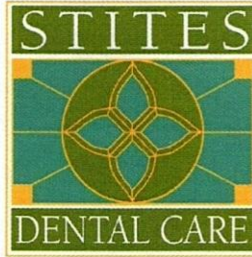
Consent for Electronic Communications and Privacy Policy

I grant my permission to Dennis A. Stites, D.D.S.and Stites Dental Care to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for Dennis A. Stites, D.D.S. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand that both Dennis A. Stites, D.D.S. and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Dennis A. Stites, D.D.S. is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Dennis A. Stites, D.D.S. is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Dennis A. Stites, D.D.S. web site with my ID and password. I also agree to immediately notify Dennis A. Stites, D.D.S. of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Dennis A. Stites, D.D.S. will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Dennis A. Stites, D.D.S. has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Dennis A. Stites, D.D.S. will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Dennis A. Stites, D.D.S. CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have provided my email and/or cellular telephone number, and consent to receiving electronic messages from Stites Dental Care.

I have read the information above regarding the secured uploading of patient information to the web site for Dennis A. Stites, D.D.S., and grant Dennis A. Stites, D.D.S. permission to securely upload my patient information to the web site.

____ Date: ____________ Relationship to Patient: ____________________
Signature of Patient, Parent or Guardian



1325 NE Douglas Street
Lee's Summit, MO 64086

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENT THOUROGHLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosure we may make of your protected health information and other important matters about your protected health information. A copy of our notice is available, and accompanies this consent. We encourage you to read it carefully and completely, prior to signing this consent.

We reserve the right to change our policy practices, as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes and how the changes may apply to any of your protected health information we maintain.

Right to Revoke: You have the right to revoke this consent at any time by giving Stites Dental Care written notice. Please understand that revocation of this consent does not affect any action we took in reliance of this consent before your received your revocation and we may decline to treat you, or continue treatment, if you revoke this consent.

I, ____, have had full opportunity to read and consent to this form and Stites Dental Care Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Patient Name: ________________________________

Signature: ____ Date: ______________________

Relationship to Patient *(if patient is a minor)*: __________________________________