Welcome

Patient ID # _____ Today's Date _____

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

SS#/SIN _____

School _____ Grade _____

Child's Home Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Phone _____

Responsible Party

Name _____

Relationship _____

Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Email _____

SS#/SIN _____

DL # _____

Who is responsible for making appointments?

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Best time to call _____

Time _____ Days _____

Mother ☐ Stepmother ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father ☐ Stepfather ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____

City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____

City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____

Amount already used _____

Max. annual benefit _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check

Credit Card ☐ Visa ☐ MC ☐ I wish to discuss the office's payment policy.

Dental & Health History *CONFIDENTIAL* Patient ID # _____

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____ How often does your child floss? _____

Is your child's water fluoridated? ☐Yes ☐No Does your child take fluoride supplements? ☐Yes ☐No

Does your child:

Suck thumb/finger ☐Yes ☐No Chew hard objects (pencils, etc.) ☐Yes ☐No

Suck/Bite lip ☐Yes ☐No Grind teeth ☐Yes ☐No

Bite/Chew nails? ☐Yes ☐No Clench jaws ☐Yes ☐No

Previous dentist _____ Address _____

Date of last dental visit? _____ _____

Has your child had difficulty with previous dental visits? ☐Yes ☐No

Child's physician _____ Address _____

Phone # _____ _____

Previous Hospitalizations/Surgeries/Serious Illnesses? When?

_____ _____

_____ _____

_____ _____

Is your child currently taking medications? ☐Yes ☐No (if yes, please list)

_____

Has your child ever taken Fen-Phen/Redux? ☐Yes ☐No

_____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐Yes ☐No (if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)?

_____

Has your child ever had any of the following:

Asthma ☐Yes ☐No Stomach, liver or kidney problems ☐Yes ☐No

Cancer ☐Yes ☐No Handicaps/Disabilities ☐Yes ☐No

Hepatitis ☐Yes ☐No Tuberculosis ☐Yes ☐No

HIV/AIDS ☐Yes ☐No Diabetes ☐Yes ☐No

Hemophilia ☐Yes ☐No Rheumatic Fever ☐Yes ☐No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ☐Yes ☐No

Congenital Heart Defect ☐Yes ☐No

Heart Murmur ☐Yes ☐No

Convulsions/Epilepsy ☐Yes ☐No

Abnormal Bleeding ☐Yes ☐No

Please explain any medical problems that your child has: _____

_____

Authorization & Release

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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my 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.

_____ _____

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

Dentist Review:

_____ _____

Signature of Dentist Date

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)*: _____