Menees Family Dentistry

8340 Mission Rd, Ste 118, Prairie Village, KS 66206

Patient Information

Today's Date: ____/____/____

Patient Name: _____ ☐ Female ☐ Male
First MI Last ☐ Married ☐ Single ☐ Child ☐ Other ____

Preferred Name: _____ **Social Security #** _____/_____/_____ **Date of Birth** _____/_____/_____ **Age**_____

Phone: _____ **Work** _____ **Cell:**_____ **Email:** _____

Address: _____
Street Apt # City State Zip

Employer: _____ **Occupation:** _____ **Are you the responsible party:** ☐ Yes ☐ No

If no: Responsible Parties Name: _____ **Social Security #:** _____/_____/_____ **DOB:** ___/_____/_____

Relationship:_____ **Home Phone:**_____ **Work:**_____ **Cell:**_____

Address:_____
Street Apt # City State Zip

Health Information

ARE YOU ALLERGIC TO: ☐ **NONE**

☐ **Codeine** ☐ **Dairy** ☐ **EPI Sensitive** ☐ **Keflex** ☐ **Latex** ☐ **Nickel/Jewelry** ☐ **Penicillin** ☐ **Sulfa** ☐ **Other** _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Yes	No	AIDS/HIV	Yes	No	Diabetes	Yes	No	Lung Disease
Yes	No	Anemia	Yes	No	Excessive Bleeding	Yes	No	Rheumatism
Yes	No	Arthritis	Yes	No	Fainting	Yes	No	Seasonal Allergies
Yes	No	Artificial Joints	Yes	No	Heart Disease	Yes	No	Seizures
Yes	No	Asthma	Yes	No	Hepatitis (Type) _____	Yes	No	Stomach Ulcers
Yes	No	Blood Disease	Yes	No	High Blood Pressure	Yes	No	Thyroid Disorder
Yes	No	Cancer (Type) _____	Yes	No	High Cholesterol	Yes	No	Tuberculosis
Yes	No	Currently Pregnant	Yes	No	Hives/Skin rash	**OTHER**		
Yes	No	Currently on Blood Thinners	Yes	No	Kidney Disease	**OTHER**		
Yes	No	Currently use tobacco	Yes	No	Liver Disease	**OTHER**		

Current Medications (Rx, and/or OTC) please add separate sheet if needed

Drug Name(s)	Dosage	Used For	Drug Name(s)	Dosage	Used For

Name and phone number of primary care physician: _____

Are you currently being treated by a physician? Yes No If yes please list doctors name, phone number, and reason for care

_____

Have you ever had a serious illness or operation? Yes No If yes please give date and treatment _____

_____

Emergency contact: **Name** _____ **Phone #**_____ **Relationship** _____

How did you learn about our office? ☐ Friend _____ ☐ Health Grades ☐ Internet Search ☐ YP

Other: _____

Why did you choose to come to our office at this time? _____

How do you feel about your past dental treatment? _____

_____

How important is it for you to eliminate future problems? _____

_____

What are your major concerns you have at this time? _____

_____

Do you have a history of gum disease in your family? _____

Dental Insurance Information

Primary:

Subscriber: _____ **DOB** _____/_____/_____ **SS #:** _____/_____/_____

Relationship to patient: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** **Private Policy ( ) Group Policy ( )**

Insurance Company _____ **Phone #** _____ **ID #** _____

Group Name/Employer_____ **Group #** _____

Claims Address _____
Street City State Zip

Secondary:

Subscriber: _____ **DOB** _____/_____/_____ **SS #:** _____/_____/_____

Relationship to patient: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** **Private Policy ( ) Group Policy ( )**

Insurance Company _____ **Phone #** _____ **ID #** _____

Group Name/Employer_____ **Group #** _____

Claims Address _____
Street City State Zip

Financial Policy/Authorizations

Financial:
I understand payment is due at the time of service and that all fees are the responsibility of the patient/responsible party, irrespective of insurance claims or benefits. I agree to pay a finance charge of 1.5% per month (18% per annum) on any unpaid balance after 90 days. I understand that any unpaid balance over 120 days may be sent to collections and I will be responsible for any and all fees associated with the collection process.

I will give 48 hours' notice for any appointment that I am unable to keep **by calling** the office. I understand I may be charged a $30.00 cancellation fee for any appointment that 48 hours' notice is not given. (For extended appointments with Dr. Menees, this fee will be $50.00).

Authorizations:
I affirm that the information given is correct to the best of my knowledge. I authorize the dentist and dental staff to perform all necessary tests for the establishment of my dental profile and for the diagnosis of disease. I also grant authority to the dentist to provide treatment for any diagnosed disease. Like any medical treatment, there are certain risks, benefits, limitations, and alternatives to treatment and no guarantee of the outcomes or cures will be given. I understand it is difficult to predict any symptoms, if any, I may encounter as a result of treatment. **I affirm that my signature represents my agreement to all the above mention terms.**

Signature of Patient, Parent, or Guardian:_____ **Date:**_____