R. Bradley Gaik, DDS
Larinda Hlavacek, DDS

ShoalCreek
DENTAL CARE

8568 N. Church Rd., K.C., MO 64157
816-792-0801

PATIENT MEDICAL AND DENTAL HISTORY

Patient Name: ______________________ ***Today's Date:*** ___/___/___

Emergency Contact: ______________ **Relationship:** ______________ **Phone:** ______________

Physician: ______________ **Phone:** ______________ **Last Exam Date:** ___/___/___

Previous Dentist: ______________ **X-Rays:** ______________ **Last Exam Date:** ___/___/___

Are you currently under medical treatment? ☐ Yes ☐ No **If Yes, please explain:** ______________

Please explain any surgery or serious illness you have had in the last 5 years: ______________

Please list any medications that you are taking, including non-prescription medications, herbs, vitamins, and oral contraceptives:

Medication	*Dosage*	*Reason*

Please list any medications that you are allergic to, or have had a reaction to: ______________

Are you allergic to Latex? ☐ Yes ☐ No **Do you use tobacco?** ☐ Yes ☐ No

WOMEN: Are you preganant or think you may be pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Please check any of the following conditions that you have, or have had in the past:

- ☐ High Blood Pressue
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Angina
- ☐ Chest Pains
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Heart Murmur*
- ☐ Mitral Valve Prolapse*
- ☐ Cardiac Pacemaker
- ☐ Stroke
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Easily Winded
- ☐ Frequently Tired
- ☐ Anemia
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Thyroid Problem
- ☐ HIV/AIDS
- ☐ Epilepsy/Convulsions
- ☐ Fainting/Seizures
- ☐ Cancer or Leukemia
- ☐ Radiation Therapy
- ☐ Hepatitis/Jaundice
- ☐ Liver Disease
- ☐ Stomach Ulcers
- ☐ Glaucoma
- ☐ Recent Weight loss
- ☐ Arthritis
- ☐ Joint Replacement*
- ☐ Joint Implant*
- ☐ Swollen Ankles
- ☐ Bleeding or Clotting Problems
- ☐ Artificial Stents or Shunts

**If you have any of the conditions with an asterisk (*), please contact our office prior to your appointment, as you may require Pre-Medication.*

Reason for today's visit: ______________

Please circle Yes (Y) or No (N) in response to the following:

- **Y N** Is fluoride taken in any form?
- **Y N** Bad breath?
- **Y N** Brush daily?
- **Y N** Floss daily?
- **Y N** Headaches, ear aches, or neck pain?
- **Y N** Gums bleed when you brush?
- **Y N** Facial pain?
- **Y N** Periodontal gum treatments?
- **Y N** Orthodontic (braces) treatment?
- **Y N** Clicking or popping in jaw joints?
- **Y N** Removable dental appliances?
- **Y N** Injuries to teeth or jaw? If Yes, please explain ______________
- **Y N** For your child, any mouth habits? (thumb sucking, pacifier, nail biting, etc.)

Have you had a serious/difficult problem associated with any previous dental treatment? ☐ Yes ☐ No

If Yes, please explain: ______________

How would you describe your current dental health? ______________

How do you feel about your teeth's appearance? ______________

Would you like to hear about ways we can improve the look of your smile? ☐ Yes ☐ No

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.

Signature of Patient ***(or parent if minor):*** ______________ ***Date:*** ___/___/___

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CONFIDENTIAL PATIENT INFORMATION

Today's Date: ____ / ____ / ____

Patient Name: ______________________________ **Preferred Name:** ____________
Last First M.I.

Date of Birth: ____ / ____ / ____ **Social Security #:** ____________ **E-Mail:** ____________

Address: ____________ **City:** ____________ **State:** ____ **Zip:** ____________

Home Phone: ____________ **Work Phone:** ____________ **Cell Phone:** ____________

Patient's/Parent's Employer: ______________________________ **Occupation:** ____________

Gender: ☐ Male ☐ Female **Status (check one):** ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Parent/Spouse: ____________ **Employer:** ____________ **Work Phone:** ____________

Person Responsible for This Account *(if different than patient)***:** ______________________________

Relationship to Patient: ______________________________

Date of Birth: ____ / ____ / ____ **Social Security #:** ____________

Address (if different than above)**:** ______________________________ **Phone:** ____________

Employer: ______________________________ **Work Phone:** ____________

Primary Insurance Company: ______________________________ **Insurance Phone:** ____________

Primary Insurance Subscriber: ____________ **Employer:** ____________

Date of Birth: ____ / ____ / ____ **Social Security #:** ____________

Do you have Secondary Dental Insurance? ☐ Yes ☐ No **If Yes, Secondary Insurance Company:** ____________

Is anyone in your family already a patient in this office? ☐ Yes ☐ No

How did you hear about Shoal Creek Dental Care? ______________________________

I authorize and request my insurance company to pay directly to the dentist 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. I also give this office permission to release my dental records to another dental provider or myself at my verbal request.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I have certain privacy rights regarding my protected health information and uses for such information. I have received a copy of Shoal Creek Dental Care's Notice of Privacy Practices, read, and understand these practices. I understand that these practices may be changed at any time. I understand I may request in writing restrictions on how my information is used or disclosed to carry out treatment, payment or health care operations. Shoal Creek Dental Care may not agree to such requests, but if agreed to then Shoal Creek Dental Care is bound by said request.

Signature of Patient ***(or parent if minor):*** ______________________________ ***Date:*** ____ / ____ / ____

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PATIENT FINANCIAL POLICY

Our office strives to provide the highest quality dental care at affordable prices. The purpose of this financial policy is to eliminate confusion or misunderstanding concerning financial arrangements offered by our office. Our office communicates this policy to each patient.

1. Payment at the time of service is expected, including the estimated portion that insurance does not cover. We accept Visa, MasterCard and Discover and offer different financing options.
2. An account statement for any balance after insurance will be mailed and payment is expected upon receipt of the statement.
3. Interest of 18% per annum will be charged on any unpaid balance over 60 days.
4. Any quotes given to you during financial arrangements are considered to be estimates. It is difficult to know the exact amount that you will owe until after insurance has paid. It is possible for the course of treatment to change during a procedure, which may change the estimated fees.
5. A $25.00 charge will be billed to your account for any returned check. We will resubmit the check for payment to the bank one time. However, if funds are still insufficient, we will not accept payments by check from you in the future.
6. While we know that there are last minute emergencies, we do ask for 24-48 hour notice for cancellations. Without notice, that time is wasted and cannot be used to assist another patient. For patients who repeatedly miss appointments, there may be a $20.00 cancellation fee.
7. Accounts delinquent over 90 days will be sent to a collection agency and a collection fee of 35% of the balance due will be charged to your account.

For Our Patients with Dental Insurance Benefits

For your convenience we are happy to submit your dental claims and accept payment from your insurance company. In order to do this you will need to present a current insurance card to our office staff in addition to completing the insurance information portion on our health history form.

We are happy to assist you in any way that we can, however, your insurance contract exists solely between you and your insurance carrier. We cannot be responsible for the limitations and exclusions determined by your particular insurance plan. Please refer to your benefits booklet, contact your employer or call your insurance company directly for a clear understanding of your dental benefits and limitations.

I have read and understand the financial policy of Shoal Creek Dental Care and agree to all the terms described in it.

Signature of Patient/Guardian: ______________________ ***Date:*** ____/____/____