TMC
TRUMAN MEDICAL CENTER
Lakewood

| Better. For Everyone.

Patient Identification Label

PATIENT INFORMATION

Please Print ***CONFIDENTIAL***

Date _____

Patient's First Name_____ **Last Name** _____ **MI** ____

Address _____

City _____ State _____ Zip _____

Home phone _____ Mobile phone _____

Birth Date _____ Social Security_____ Driver's License _____

Sex ☐M ☐F Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Guardian's Name (Person responsible for payment for services) _____

Guardian's address same or _____City/State/Zip_____

Guardian's Social Security Number _____DOB _____

Guardian's phone number

Person to contact in case of an emergency or if we are unable to reach you at your contact numbers:

Name _____ Phone number(s) _____

RESPONSIBLE PARTY/POLICY HOLDER INFORMATION

If you checked yes, please list all family members who are currently patients in our practice

_____ _____

_____ _____

Primary Insurance Information

Name of insured/guarantor/subscriber (as printed on insurance card)

_____

Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other

Insured Social Security Number_____ Insured Birth Date _____

Policy number/Subscriber ID _____

Group number _____Medicaid number_____

Employer _____ Insurance Company _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Secondary Insurance Information

Name of insured/guarantor/subscriber (as printed on insurance card)_____

Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other

Insured Social Security _____ Insured Birth Date _____

Policy Number/Subscriber ID _____

Group number _____ Medicaid number _____

Employer _____ Insurance Company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

You should be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not mean you cannot be treated, but should be considered in making the decision to submit to dental treatment.

Sometimes the nerve of a tooth may die or become infected. An undetected non-vital tooth may flare up during any dental treatment and may require endodontics (root canal) treatment to maintain it, or removal of the tooth.

Root canal therapy may have to be terminated before completion because of unforeseen difficulties. Occasionally even completed root canals are not successful. Under these conditions the tooth will have to be removed.

There is a risk that during or following treatment other problems may occur. These can include but are not necessarily limited to: reaction to local anesthetics and/or medicine, fracturing of tooth during removal, pain or discomfort, injury resulting from the use of high speed dental equipment, and occasionally prolonged or permanent numbness of the lip and/or tongue.

I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the recommended method of treatment for my mouth. I understand that for a good result and to lessen the dangers of complication, the following conditions are essential on my part: excellent oral hygiene, proper diet controls, strict adherence to instructions, and cooperation in keeping appointments.

Treatment plans can change due to unforeseen conditions which may become known during treatment.

I understand that there is no warranty or guarantee to my result and /or care. I also understand that I can, at any time, ask for and be told in detail of all possible risks related to my treatment.

In case of minor patients, it is required that one of the parents or legal guardian accompany the child and remain in the waiting room during all procedures.

I accept the above conditions and hereby voluntarily give consent to Truman Medical Center Lakewood Dental Clinic and the dental staff to provide dental care encompassing routine diagnostic procedures and dental treatment deemed necessary or desirable.

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or 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 doctor or doctor's group insurance benefits otherwise payable to me.
I understand that this is a fee-for service clinic and 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. ***Please note TMC Dental Care does not provide discounts based on income.***

X_____ _____

Signature of patient or parent/legal guardian **Date**

TMC LAKEWOOD DENTAL CLINIC

Acknowledgement of Notice of Privacy Practices

By signing this form, I agree that Truman Medical Centers (TMC) staff has given me a copy of the Notice of Privacy Practices.

_____	_____
Signature of Patient or Authorized Representative	Date
_____	_____
Printed Name	Date
_____	_____
Witness	Date
_____	_____
Guardian's Signature	Relationship to patient
_____	_____
Interpreter Signature, if necessary	Date

Dental Practice Missed Appointment Agreement

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or late canceling an appointment means we are unable to fill this appointment time with another patient who desperately needs care.

Our policy requires:

- Appointment Confirmation: If appointment is not confirmed by text, e-mail or phone call by 3:00 pm the day before appointment, your appointment may be given to another patient. It is **your responsibility to call.** __ **Initials**

- Timely Cancellations: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. Cancellations made with less than 24 hours' notice will be considered a missed appointment. __ **Initials**

- On Time Arrivals: If you are more than 10 minutes late to your appointment, we will give your appointment away to another patient. This will be considered a missed appointment. __ **Initials**

- Compliance: Patients are allowed two (2) missed appointments per six (6) month period. The missed appointment will be noted in the patients' chart. __ **Initials**

Many patients use TMC Lakewood Dental services. Your help in keeping your appointments enables us to provide better and timelier care for all our patients

_____	_____
Patient/Guardian Signature	Date

Updated 2016 Medical History(Copy)

Patient Name: Birth Date: Date Created:

Disclaimer

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.

PLEASE CHECK APPROPRIATE ANSWER:

Is your general health good?	○ Yes ○ No	
Has there been a change in your health within the last year?	○ Yes ○ No	If yes
Have you been hospitalized or had a serious illness in the last three years?	○ Yes ○ No	If yes
Are you being treated by a physician now? For	○ Yes ○ No	If yes
Have you had any problems with prior dental	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you in pain now?	○ Yes ○ No	

WOMEN ONLY:

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

ARE YO ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Food
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes	
Do you use tobacco in any form?	☐	If yes	
Other?	○ Yes ○ No		

CURRENT HEALTH:

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

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

Have you ever had any serious illness not listed	○ Yes ○ No	If yes	
PLEASE LIST ANY MEDICATIONS OR 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:

X Date:_____