During your initial dental visit, you'll receive a comprehensive examination of your teeth, gums, and mouth to assess your oral health and identify any issues. Based on this evaluation, we then can develop a personalized treatment plan tailored to your needs.

Dr. Brendan Duede, D.D.S

Patient Health Record

Patient Information

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Email: _____

Sex: ❑ M ❑ F Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Partnership ❑ Widowed

Employer or School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse, partner or parent name: _____

Person to contact in case of an emergency: _____ Phone: _____

How did you learn about our practice or whom may we thank for referring you? _____

Who is responsible for your account and payment? (if different from previous listing): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Birthdate:_____

Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security #_____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security #_____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dental History

Reason for today's visit: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____

Former dentist's name: _____ Phone: _____

Check if you have any problem with the following:

❑ Bad breath
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between certain teeth
❑ Grinding teeth
❑ Loose teeth or broken fillings
❑ Periodontal treatment
❑ Sensitivity to any of the following: cold, hot, sweets
❑ Sensitivity when biting
❑ Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Your physician: _____ Date of last visit: _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No

If yes, describe: _____

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, give approximate dates: _____

Women: are you pregnant? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Are you taking birth control? ❑ Yes ❑ No

Check if you have or have had any of the following:

- ❑ Anemia
- ❑ Arthritis, rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints, pins, etc.
- ❑ Asthma
- ❑ Bleeding abnormally
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Congenital heart lesions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV AIDS
- ❑ Jaw pain
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Sexually transmitted disease
- ❑ Stroke
- ❑ Swelling of feet or ankles
- ❑ Thyroid problems
- ❑ Tobacco use
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer

List medications you are currently taking and the correlating diagnosis:

Medication	**Diagnosis**

Please list any allergies you may have:

Allergy	**Allergy**

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

_____ _____

Patient or Guardian Signature *Date*

DENTAL BENEFIT PLAN INFORMATION

We recommend that you read your insurance policy thoroughly so you are fully aware of the benefits provided and the limitations imposed. You are ultimately responsible for the total cost of your treatment. Your dental plan is designed to help offset the cost of your dental care and is not intended to cover the dentist total fee. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service. If an insurance carrier has not paid within 90 days of billing, any unpaid balances are due in full from the patient.

In order for us to help you obtain dental benefits from your insurance carrier please fill out this form completely. If you have any questions or need assistance please ask. We will be happy to assist you.

RESPONSIBLE PARTY

Name of person responsible for account _____

SSN ___/___/___ DOB ___/___/___ Relationship to Patients _____

ADDRESS FOR BILLING _____

Home Phone # _____ Work Phone # _____ Cell or Pager # _____

*A financial agreement must be signed to initiate third party billing

PRIMARY INSURANCE

Employee Name _____ SSN ___/___/___ DOB ___/___/___

Home Phone # _____ Work Phone # _____ Cell or Pager # _____

Home Address _____

Employer _____

Business Address _____

Insurance Carrier _____ Phone # _____

Claim Submission Address _____

Group # _____ Policy # _____

LIST ALL PATIENTS COVERED UNDER THIS POLICY:

NAME	DOB	RELATIONSHIP TO INSURED	PLEASE INDICATE SCHOOL NAME IF DEPENDENT IS OVER 18 YEARS OLD AND A FULL TIME STUDENT	M/F

SECONDARY INSURANCE

Employee Name _____ SSN ___/___/___ DOB ___/___/___

Home Phone # _____ Work Phone # _____ Cell or Pager # _____

Home Address _____

Employer _____

Business Address _____

Insurance Carrier _____ Phone # _____

Claim Submission Address _____

Group # _____ Policy # _____

LIST ALL PATIENTS COVERED UNDER THIS POLICY:

NAME	DOB	RELATIONSHIP TO INSURED	PLEASE INDICATE SCHOOL NAME IF DEPENDENT IS OVER 18 YEARS OLD AND A FULL TIME STUDENT	M/F

I _____ AUTHORIZE MY INSURANCE BENEFITS TO BE PAID Directly to Brendan Duede

SIGNATURE _____ DATE _____

* Please present your insurance card with this completed form for verification of benefits.

Brendan Duede DDS

13025 S Mur-Len #250, Olathe KS 66062 / 913-764-1169

Financial Policy

Thank you for choosing Brendan Duede DDS Our practice is dedicated to making your treatment and overall experience in our office a success. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Please be advised that payment is expected at the time services are rendered. We are pleased to offer you the following payment options.

Payment Options:

FULL PAY CASH DISCOUNT:

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check at the start of treatment. Any insurance benefits will be assigned payable directly to you.

NO INTEREST PAYMENT PLANS FROM CARE CREDIT:

- Allow you to pay over time with NO INTEREST for balances over $300
- No annual fees or pre-payment penalties
- Apply online at CareCredit.com or call 1-800-365-8295
- Approval required prior to appointment date

TWO EQUAL PAYMENTS FOR TREATMENT PLANS REQUIRING MORE THAN 2 APPOINTMENTS.

- Initial payment due at start of treatment
- Second payment due day of delivery of major treatment

DENTAL BENEFITS

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement of your treatment. We can make no guarantee of any estimated coverage or payment. Please note your insurance policy is an agreement between you and your employer and the insurance company. The estimate provided by this office is considered a guideline. You will be required to pay any estimated deductible and co-pay amounts in full the day treatment is rendered.

Please note:

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 48 hours notice.

When you pay by check and your check is dishonored or returned for any reason, you authorize Brendan Duede office to electronically debit your account for the amount of the check plus a processing fee of $30. The use of a check for payment is your acknowledgment and acceptance of this policy and its terms.

Financial Consent:
I understand that I have the final responsibility for payment of all fees for service rendered on my behalf. I have fully read, and understand and consent to all of the above terms.

Patient, Parent or Guardian Signature Date

Thank you for placing your trust in us to provide your dental care!

Patient Acknowledgment of Receipt of Privacy Practices Notice

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature:_____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by:_____ Date: ___/___/___