amazingsmiles
family & cosmetic dentistry

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you. Thank you and we are glad you are here!

ABOUT PATIENT

Today's Date: 2-24-16 E-Mail Address: ccjandsj@yahoo.com

Patient's Name: Jackson, Sylvia I (Last, First MI) Date of Birth: 05 - 07 - 57

Preferred Name: Age: 58

Male: ☐ Female: ☑

Social Security Number: 514 - 68 - 2628 Home Number: (____) ____ - ____

Home Address: 6221 NW Hogan Dr. Work Number: (913) 667 - 8082

City: Parkville State: MO Zip: 64152 Cell Number: (913) 226 - 4998

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

Can we text appointment information to your cell phone? Y: ☑ **N:** ☐ **Email? Y:** ☐ **N:** ☑

Employer Name: Berkel & Co Contractors, Inc. Occupation: Union Tax Specialist

Employer Address: 2649 S 142nd Street How long employed there? 11 years

City: Bonner Springs State: KS Zip: 66012

How did you hear about us? (Include referral name, if applicable): April Lee

DENTAL HISTORY

Your current dental health is: Good: ☑ **Fair:** ☐ **Poor:** ☐ **Do your gums ever bleed? Yes:** ☐ **No:** ☑

Do you like the color of your teeth? Yes: ☑ **No:** ☐ **Do you like the size and shape of your teeth? Yes:** ☐ **No:** ☑

Are you afraid of needles? Yes: ☐ **No:** ☑ **Do you feel like you have cavities at most check-ups? Yes:** ☐ **No:** ☑

Do you have any dental fears? No

How can we make your dental visit more comfortable? _____

What would you change about your smile if you could? have all of my lower teeth.

Why have you come to the dentist today? Cavity

How long since your last dental visit? over a year Name of previous dentist: Drake

Why did you leave your last dentist? Not totally happy

What else would you like to tell us? Not happy with the partial plate from the previous dentist. Not happy he pulled lower teeth.

Drake has lower plate, when tech cleaned my teeth she popped my crown and I had to have it replaced. The bottom plate never fit prior to that and then really did not fit after that.

---OVER---

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EMERGENCY CONTACT/SPOUSE INFORMATION

His/Her Name: Chris Jackson Employer: Schmuhl Brothers

Date of Birth: 12 - 13 - 1962 SS#: 515 - 72 - 6730 Work #: (_____) _____ - _____

Cell #: (913) 687 - 7112

DENTAL INSURANCE INFORMATION

Name of Employee: Sylvia Jackson **Name of Employer:** Berkel & Co Contractors, Inc.

Patient's Relationship to the employee: self Insurance Co. Name: Cigna

Employee's ID#: U2481957901 Address: _____

Employee's DOB: 05 - 07 - 1957 Group# 3328284 Phone # for customer service: (800) 244 - 6224

WWW.CIGNA.COM

You may be asked to present this card when you receive care. The card does not guarantee coverage. You must comply with all terms and conditions of the plan. Willful misuse of this card is considered fraud.

INPATIENT ADMISSION:
Your Network provider must call the toll-free number listed below to pre-certify the above services. Refer to your plan documents for your pre-certification requirements. Failure to do so may affect benefits. In an emergency, seek care immediately, then call your primary care doctor as soon as possible for further assistance and directions on follow-up care within 48 hours.

Send Claims to:

P.O. Box 182223, Chattanooga, TN 37422-7223

Customer Service: 1-800-244-6224

We encourage you to use a PCP as a valuable resource and personal health advocate.

AWAY FROM HOME CARE

Sylvia's employer's Ins

Berkel & Co

myCigna.com

Administered By Cigna Health and Life Insurance Co.
Coverage Effective Date: 01/01/2015
Group: 3328284
Issuer (80840)
ID: U24819579 01
Name: Sylvia Jackson

Berkel & Company
RxBIN 017010 RxPCN 02150000 MultiPlan
Network Savings Program

Open Access Plus
No Referral Required

PCP Visit	$25
Specialist	$40
Hospital ER	$100
Urgent Care	$50
Rx	$10/30/60
Network Coinsurance:	
In	90%/10%
Out	50%/50%

NMCWEBC

Humana.com

Member Service: 1-800-233-4013
Dental Provider Service: 1-800-833-2223

HumanaDental Claims Office
P.O. Box 14611
Lexington, KY 40512-4611

HumanaDental Insurance Company

Card Issued: 03/28/201

Chris' employer's Ins.

Schmuhl Bros

Humana.

Dental PPO
Subscriber: **CHRISTOPHER C JACKSON**
Group Name: **SCHMUHL BROTHERS**

Member ID:	Member Name:
104452296 01	**CHRISTOPHER C JACKSON**
104452296 02	**SYLVIA JACKSON**

Coverage Type: **ESP**
Group ID: **549914**

Benefit: Dental

TIME 9:52 AM

Amazing Smiles Of Kansas City

DATE 4/23/2015

MEDICAL HISTORY

PATIENT NAME Sylvia Jackson Birth Date 5-7-1957

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.

Are you under a physician's care now?	Yes ◉ No ○	If yes, please explain:	Diabetes
Have you ever been hospitalized or had a major operation?	Yes ◉ No ○	If yes, please explain:	Hysterectomy
Have you ever had a serious head or neck injury?	Yes ○ No ◉	If yes, please explain:	
Are you taking any medications, pills, or drugs?	Yes ◉ No ○	If yes, please explain:	Vitamins, Metformin,
Do you take, or have you taken, Phen-Fen or Redux?	Yes ○ No ◉		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes ○ No ◉		
Are you on a special diet?	Yes ○ No ◉		
Do you use tobacco?	Yes ◉ No ○		
Do you use controlled substances?	Yes ○ No ◉		

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain:

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	Shingles	○ 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 Problem	○ 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	Swelling of Limbs	○ 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 above? ○ Yes ◉ No

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 Sylvia Jackson DATE 2-24-2016

NOTICE OF PRIVACY PRACTICES

Amazing Smiles of Kansas City
Dr. Kelly McCracken
8915 State Ave
Kansas City, KS 66112
P: (913) 788-7600
F: (913) 788-7601
info@amazingsmileskc.com
Gina Haas, Office Manager

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all.

Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call, text, e-mail or write ("communicate") to remind you of scheduled appointments, or that it is time to make a routine appointment. We will communicate in the ways that you designate on your New Patient Form. We may also communicate to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on a phone number provided or with someone who answers your phone if you are not available.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written

request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.

- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal e-mail address. We will accommodate these requests if they are reasonable. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the documents are stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the officeperson at the address, fax or E-mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or e-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

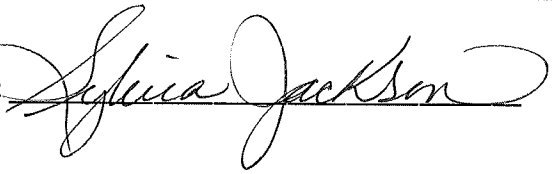
FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Amazing Smiles of Kansas City's Notice of Privacy Practices.

Patient name: Sylvia Jackson

Signature:  Date: 02 / 16 / 20 16

Witness: _____

FOR OFFICE USE ONLY:

We attempted to obtain written Acknowledgement of Receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the Acknowledgement
- ☐ An emergency situation prevented us from obtaining the Acknowledgement
- ☐ Other (please specify)

_____

_____

_____

amazingsmiles
family & cosmetic dentistry

Dr. Kelly McCracken
(913) 788-7600
www.amazingsmileskc.com

FINANCIAL POLICIES

So that we may better serve our patients, we offer the following financial arrangements for the services that we provide.

PAYMENT BY APPOINTMENT:
Full payment is due as services are rendered. For your convenience, we accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit. Please inquire if you are interested in applying for Care Credit.

INSURANCE PAYMENTS:

AS A *COURTESY*, we will file your insurance claim for you. We provide this service as a courtesy only and it is not meant to be a substitute for payment. Many insurance companies pay fixed allowances for certain procedures while many others pay a certain percentage of the charge.

Many insurance companies have a list of "Reasonable and Customary Fees". These fees can vary greatly between insurance carriers. We verify through the National Dental Advisory Board that our fees are *at the average for our 66112 zip code* so we can offer quality dental care at a fair price.

As a courtesy, we will attempt to contact your insurance company for benefit verification. Verbal confirmation is NOT a guarantee of benefits or payment, as exclusions and limitations may apply.

Our office recommends and provides dental care to help you achieve optimal dental health and not whether or not your insurance company covers it. *It is your responsibility to know your policy.* It is your responsibility to pay any deductible amount, co-insurance or any other balance not covered by your insurance plan.

- **All co-pays and deductibles must be paid at the time of your appointment. We will *estimate* as close as possible what your treatment's "patient portion" or "out-of-pocket" expense will be. If there is any difference after we receive final payment from your insurance company, you will receive a statement for the balance for which you are responsible or a credit to your account unless you request a refund.**
- **All charges are your responsibility whether your insurance pays or not. Not all services are a covered benefit in all contracts.**
- **We will make every attempt to get payment from your insurance company, however; any balance unpaid by insurance after 60 days will become your responsibility. You will be expected to pay the balance and then you will be reimbursed when your insurance company pays.**

amazingsmiles
family & cosmetic dentistry

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www.amazingsmileskc.com

FINANCIAL POLICIES (continued from page 1)

INTEREST CHARGES:
Patient balances 60 days and older will be assessed an interest charge of 1.5% per month, or 18% APR, with a minimum of $1.00.

COLLECTION CHARGE:
Any account sent to an outside collection agency will assess a $25 collection fee.

INSUFFICIENT FUNDS CHARGE:
Presented checks with insufficient funds or a placed "stop payment" on an issued check will be charged at $25 fee for processing. Insufficient funds checks will not be reprocessed and you will be asked to make a payment immediately in the form of cash or a Cashier's check. No further appointments will be made until the fee is paid.

MISSED/CANCELLED APPOINTMENT CHARGE:
Any appointment not kept or cancelled without 24-hour notice, may be subject to a charge of $10 per 10 minutes of scheduled time with a minimum charge of $50. No further appointments will be made until the fee is paid.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ITS TERMS. IF I HAVE INSURANCE, I ALSO DIRECT MY INSURANCE CARRIER TO ISSUE PAYMENT DIRECTLY TO AMAZING SMILES OF KANSAS CITY.

Sylvia Jackson

Patient/Responsible Party signature

2-24-2016

Date