Date:_____

Dr. Justin Schlaikjer, D.D.S., M.S.

Patient's Name _____
Last First Middle

Mailing Address _____
Address City State Zip

Patient Date of Birth _____Patient S/S#_____ Female/Male Married/Single/Child/Other

EMAIL_____

Home Ph. _____ Work Ph. _____ Cell Ph._____

Employer _____ Occupation_____

If patient is a minor, Responsible party information: Name: _____
Last First Middle

Spouse's Name _____
Last First Middle

Spouse's Employer _____Spouse's Occupation _____

Is an immediate family member a patient here?_____ Name_____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Self _____ Other _____
Yes/No Last First Middle
If "other" please complete:
Date of Birth _____ S/S#_____ Relationship to Patient _____

Address _____
Street City State Zip

How long at this address _____ Home Ph. _____ Work Ph. _____

Dental Insurance Information

Insured's Name _____ S/S#_____ Date of Birth_____

Insured's Employer _____
Zip
Insurance Company _____ Group No. _____ ID No. _____

Insurance Co. Address _____
Do you have any dual dental coverage? ☐Yes ☐No

Insured's Name _____ S/S#_____ Date of Birth_____

Insured's Employer _____
Zip
Insurance Company _____ Group No. _____ ID No. _____

Insurance Co. Address _____

Emergency Information

Name of nearest relative not living with you_____

Address _____Relation_____ Phone number_____

Reason for today's visit _____

1. Are you having pain or discomfort at this time?..... Yes No
2. Have you been a patient in the hospital during the past two years?..... Yes No
3. Have you been under the care of a medical doctor during the past two years?..... Yes No

Physician's Name _____

Address _____ _____ Phone No. _____

4. Have you taken any medication or drugs during the past two years?..... Yes No
5. Are you now taking any medication, drugs, or pills?..... Yes No

If yes, please list: _____

_____

6. Are you currently taking aspirin daily? Yes No What dose?_____

7. Do you take a blood thinner? Yes No Name of Med_____ Dose_____

8. Do you require a pre-medication (Antibiotic) for dental visits? Yes No Medication: _____ Dose:_____

9. Are you aware of being allergic to or have you ever reacted adversely to any medication or substances?..... Yes No

If yes, please list: _____

10. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Murmur……	Yes	No	Venereal Disease……..…	Yes	No	Diabetes……..Yes		No
Heart Pacemaker……..…	Yes	No	Hepatitis A (infectious)……	Yes	No	Thyroid Problems…….	Yes	No
Mitral Valve Prolapse……	Yes	No	Hepatitis B …..……..	Yes	No	Tuberculosis…….	Yes	No
High Blood Pressure……..	Yes	No	Hepatitis C…….…….	Yes	No	Asthma…….	Yes	No
Heart Surgery…….	Yes	No	A.I.D.S…….……	Yes	No	Artificial Joints……	Yes	No
Rheumatic Fever……	Yes	No	H.I.V. Positive……..……..	Yes	No	Psychiatric Treatment….	Yes	No
Epilepsy or Seizures……..	Yes	No	Bleeding Problems / Hemophilia…..	Yes	No	Cortisone Medicine……	Yes	No
Fainting or Dizzy Spells……	Yes	No	Radiation Therapy……..……	Yes	No	Cancer…….	Yes	No
Latex allergy…….	Yes	No	Dementia/ Alzheimer's……..……Yes		No	Cancer type: _____		

11. Do you Smoke? Yes No If yes: # of packs per day _____ ; # of Cigarettes per day_____
12. Do you use Smokeless Tobacco? Yes No

For Women Only:

Are you pregnant? ☐ Yes, what month? _____ ☐ No
Are you nursing? ☐Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____ Date_____

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

ANY PORTION OF A REMAINING BALANCE AFTER NINETY (90) DAYS WILL BE SENT TO A COLLECTION AGENCY.

Patient_____ Date_____

Parent or Responsible Party_____ Relationship to Patient_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PURPOSE: This for, is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this Office's Notice of Privacy Practices.

_____
Printed Name

_____
Signature

_____
Date

Authorization to Release Information

PURPOSE: This form is used to obtain authorization to release information regarding yourself, covered under the Privacy Act to people other than yourself.

I, _____, give the persons listed below permission to inquire about my account and/or procedures being performed within Dr. Schlaikjer's office.

_____ _____
Printed Name Relationship

_____ _____
Printed Name Relationship

_____ _____
Printed Name Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

OFFICE POLICIES FORM

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 10777 Sunset Office Drive, Suite 310 Sunset Hills, MO 63127:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7.Clinical documentation is done with artificial intelligence. Information is kept in the office and is not shared with other entities. 8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be suspended on their written representation that accounting would likely impede their activities.

9.Cancellation policy: If the patient cancels or misses 2 appointments, your future visits will be cancelled and will be dismissed from the practice. The patient will be referred back to their general dentist for another periodontist referral

Patient Signature: ______ **Date:** _____

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be sent to Collections. If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account. I have read, understand and agree to the terms and conditions of this Financial Agreement

Patient Signature: _____ **Date:** _____

MEDIA CONSENT FORM

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for educational purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:

The photographic/video images, and/or testimonial will be used for: Educational Purposes/Study Clubs

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Patient Signature: _____ Date: _____