Sheila R. Jungmeyer D.D.S., P.C. and Dr. Samantha Hindupur D.D.S.
246 NE Tudor Rd.
Lee's Summit, MO 64086
816-554-1600

Patient Information

Last Name:______________________ First Name:________________________ MI_____ SS#_____________

Address_________________________ City_______________ State_________ Zip code__________

Email______________________ Home Phone___________(W)___________(C)_________________

DOB:___/___/___ M / F Marital Status: Single / Married / Separated / Divorced / Widowed / Other

Employer________________________________ Occupation_______________________________________

Address__________________ City______________ State_________ Zip Code____________________

In case of emergency, who should we contact?________________ Relationship_________ Number_______

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

Insurance Information

Primary Insurance Company_________________ Group#_____________ Carrier______________________

Subscriber ID#____________________________ DOB___/___/___ Insurance number_____________

Secondary Insurance Company_______________ Group#_____________ Employer____________________

Subscriber ID#____________________________ DOB___/___/___ Insurance number_____________

I understand that the information that I have provided today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Name_____________________ Patient Signature________________ Date___/___/___

Parent/Guardian Name________________ Signature______________________ Date___/___/___

Have you ever had or have any of these conditions that would require you to take a pre-

med before your dental appointment? (Please circle all that apply)

Artificial Bones/Joints/Valves   Pacemaker   Heart Murmur
Bacterial Endocarditis   Stints/Shunts   Mitral Valve Prolapse
Heart Surgery   Heart Attack   Stroke/CHF

Have you ever been required to take an antibiotic before your dental treatment?   Yes   No

Have you ever had or have any of the following diseases, allergies, or medical conditions? (Please circle all that apply)

Blood Thinners   Bisphosphonate Therapy (Osteoporosis)   Hepatitis (A,B, or C)
HIV+ (AIDS)   Rheumatic or Scarlet Fever   Angina requiring Nitroglycerine
Hepatitis (A,B, or C)   Cancer/Chemotherapy/Radiation   High or Low Blood Pressure
Hemophilia   Abnormal Bleeding   Anemia
Diabetes   Epilepsy   Seizures   Tuberculosis (TB) Kidney Problems   Asthma
Severe Headaches   Frequent Headaches   Fainting Spells
Fever Blisters   Herpes   Psychiatric Problems
Drug or Alcohol Abuse   Sinus Problems

Allergic: Dental Anesthetics   Latex   Penicillin   Erythromycin   Aspirin   Codeine   Other

Medical and Dental History

When was your last dental cleaning and x-rays? ___/___/___   Was a pano taken at that time? **Y/N**

Have you ever experienced an adverse reaction to any dental treatment?   Yes   No

If yes please explain____

Do your gums bleed?   Yes   No   Do you have any TMJ or jaw pain?   Yes   No

Physician's Name_______________________   Phone______________________   Last visit__/__/__

Have you had any serious illnesses or operations? **Y/N** explain____

Are you currently taking any medications? **Y/N** explain ____

Women: Are you pregnant? **Y/N**   Nursing **Y/N**

Financial Agreement

Our office accepts numerous insurance plans. It is each patients responsibility to know the exact requirements of their insurance plan. We will need the correct insurance information for us to file the claims on your behalf. It is necessary for you to notify us immediately of **ANY** changes in your coverage. By signing this agreement you

are authorizing us to submit your insurance and receive payment on your behalf. We will file the insurance claims on your behalf as a courtesy, however this does not absolve you of full responsibility for the charges incurred for treatment. It is your responsibility to pay the portion insurance does not cover at the time of service.

We will send a pre-treatment for all major cases. This includes crowns, bridges, dentures, and partials. It is the patients responsibility to pay the portion stipulated by the insurance company, if any changes occur from the time of the pre-treatment and the actual payment this is also the patients responsibility to pay. All of the pre-treatments are estimates from your insurance company and **NEVER** a guarantee of benefits. All Patients are required to pay their portion at the time of service.

We accept cash, personal checks, MasterCard, Visa, Discover and American Express. We also have financing available for those who qualify for Care Credit.

Our policy regarding minors states that the adult present with the child is responsible for the portion insurance does not pay. Custodial and financial arrangements are to be worked out among the parents prior to the appointment.

Cancellation Policy

Our office appreciates as much advance notice as possible for any reason you may need to cancel. We are very flexible and understanding for last minute illness and issues beyond your control. Our policy will be that if on any occasion, you do not show for an appointment, your account will be charged $50.00 for that visit. Cancellations made 48 hours in advance will not be subject to the cancellation fee.

Signature__________________________________ Date______________________________________

We offer Saturday appointments, one per month. If you schedule on a Saturday and need to cancel your appointment we will need 48 hour notice. If we do not receive one there will be a charge of $50.00 to your account. The reason for this cancellation policy is due to the high volume of patients that need these appointments.

Signature__________________________________ Date______________________________________

Notice of Privacy Practices Acknowledgement

Under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy

regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain normal health care operations such as quality assessments and physician certifications.
- Obtain payment from third-party payers.

I understand you will be contacting me and perhaps leaving messages at the numbers provided on the patient information form. I also acknowledge that I have been given the Notice of Privacy Practices.

Patient Signature_______________________________ Date_______________________________