Ryan S. Ferns, DDS LLC
1771 NW Burdett Crossing
Blue Springs, MO 64015

Patient Information

Please Print:	☐ Single ☐ Married ☐ Divorced ☐ Widowed
First:_____ Middle:_____ Last:_____ Jr/Sr_____	
Street:_____ City:_____ State:_____ Zip_____	
Patient Social Security #:_____	Patient D.O.B.: _____ Sex: M or F
If child, Parent Name- First: _____ Middle:_____ Last: _____	
Home Phone:_____	Work Phone:_____
Cell Phone: _____	Email Address:_____
Occupation: _____ Employer: _____ Address: _____	
Spouse / Parent- First: _____ Middle:_____ Last: _____	
Work Phone:_____	Cell Phone: _____
Occupation: _____ Employer: _____ Address: _____	
Emergency Contact: _____	Phone: _____
How did you hear about our office? (if patient, please list specific name) _____	

Primary Insured		Secondary Insured	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber	☐Self ☐Spouse ☐Child ☐Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

Preferred Dental is dedicated to helping you keep your smile healthy and beautiful for a lifetime. Our office will do everything possible to help you understand and make the most of your dental insurance benefits. ***As a courtesy***, we will complete and submit dental insurance forms to your insurance company to achieve the maximum reimbursement to which you are entitled. ***We can only estimate the amount your insurance company will pay.***

By signing this agreement**, you are indicating that you understand and agree that you are solely responsible for all fees, including those not paid by your insurance company. These include any deductible amount, any amount that would be paid *as a benefit* by insurance and insurance exclusions and/or limitations. We will file your insurance only under these terms. Unless previous arrangements are made, payment is expected at time of service.** _____ *[Please initial]*

Dr. Ferns takes your oral health very seriously, but before we start your dental treatment we need some brief information on your medical history as it may affect dental care. **ALL information is CONFIDENTIAL.**

Date of last dental visit:_____	Date of last dental Xrays: _____
Why did you leave your last dentist? _____	
What is your current dental concern? _____	
Are you currently under a physician's care? ☐ Yes ☐ No Physician's Name:_____ Phone:_____	
Have you been hospitalized for surgery or illness? ☐ Yes ☐ No Please explain:_____	Are you taking any medications, including non-prescription? ☐ Yes (please list below) ☐ No
If yes, **please list medications/ reason:** _____ _____ _____ _____	
Are you allergic to had ill reactions to the following: ☐ Penicillin ☐ Codeine ☐ Latex ☐ Sulfa drugs ☐ Local Anesthetics ☐ Metals	
List any medications that you are allergic to: _____ _____ _____ _____	
Are you taking or have taken Bisphosphonates? (FOSAMAX, ACTONEL, BONIVA) or IV Bisphosphonates (ZOMETA, AREDIA) ☐ Yes ☐ No	
If yes, for how long? _____	Are you taking or have taken any steroid / cortisone therapy in last two years? ☐ Yes ☐ No

Do you have a history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**		**Y**	**N**
Rheumatic Fever			Asthma			Thyroid Disease			Artificial Joints		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitra Valve Prolapse			Anemia			Fainting or Dizziness			Mouth sores / growths		
Diabetes			Anticoagulant Therapy			Ulcers			Drug Addiction		
Pace Maker			Venereal Disease			Arthritis			Alcoholism		
High Blood Pressure			HIV Positive / AIDS			Latex Allergy			Tobacco use		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Teeth Grinding/Clenching		
Heart Problem			Excessive Bleeding			Cancer (Type:_____)			Other Disease or illness:		
Stroke			Hepatitis (Type:___)			Chemotherapy					
Lung Disease			Liver Disease			Radiation Treatment					
Breathing Problems			Kidney Disease			Any type of Implant			*For women:*		
Tuberculosis			Dialysis			Any type of Transplant			☐ Pregnant ☐ Nursing		

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. _____ [*Please Initial]*

Dental Health evaluation	Y	N		Y	N
Does food catch between your teeth?			Do you have problems of the Jaw?		
Do your gums bleed when brushing?			If yes, ☐ Clicking ☐ Pain (joints, ear, side of face)		
Have you noticed gum swelling around teeth?			☐ Difficulty chewing ☐ Difficulty opening / closing		
Do you have an unpleasant taste / odor in your mouth?			Have you ever had any teeth removed? How long have they been missing? _____		
Do you avoid any area of the mouth while brushing?			Do you wear artificial dentures? If so, age of dentures: _____		
Are you dissatisfied with your teeth and their appearance?			If wearing dentures, are you interested in new dentures?		
Are you deeply concerned about the finance required to return your teeth to excellent dental health?			If not, do you feel that you will eventually wear artificial dentures?		
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?			Are your teeth sensitive to: ☐ Heat ☐ Cold ☐ Sweets ☐ Biting Pressure		

I consent to the diagnostic procedures and treatment by the dentist necessary for proper care. I consent to the dentist's use and disclosure of my records (child's records) to carry out treatment, obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or child's records) to the following persons who are involved in my care (child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke it in writing.

_____ _____

_____ _____

2 Day Cancellation Policy: For any scheduled appointment, we require two business days notice if you are unable to keep your appointment. **Failure to give this notice may result in a $50.00 charge per hour scheduled.** We are aware that emergencies arise, and we are not insensitive to the issues. However, if you do not call us to let us know what is occurring, we reserve the right to impose this fee. We cannot provide our patients with the level of excellence expected of us if we do not have your cooperation with respect to keeping your appointment. _____ *[Please Initial]*

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. **I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts.** By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental insurance payor. _____ [*Please Initial]*

Acknowledgement of Receipt of notice of Privacy Practices

I, _____ , have received a copy of this offices Notice of Privacy Practice
[Please Print Name]

Signature:_____ Date: _____