Ron J. Burgmeier, D.D.S., P.A.

Patient Health Record

_____/_____/_____
DATE

NAME (Last) (First) (Middle) SOCIAL SECURITY NUMBER

HOME ADDRESS CITY STATE ZIP HOME PHONE

BUSINESS ADDRESS CITY STATE ZIP BUSINESS PHONE

OCCUPATION EMPLOYER E-MAIL ADDRESS CELL PHONE/PAGER

DATE OF BIRTH SEX WEIGHT MARITAL STATUS SPOUSE/PARTNER'S NAME

TYPE OF DENTAL INSURANCE (if applicable) CERTIFICATE # GROUP #

REFERRED BY PREVIOUS DENTIST

If you are completing this form for another person, what is your NAME and RELATIONSHIP to that person? _____

What is the NAME AND ADDRESS of who is responsible for payment of charges incurred? _____

MEDICAL HEALTH

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Name and address of physician _____

Have you ever been a patient in a hospital or under the care of a physician during the past 5 years? ..... Yes ❑ No ❑

If yes, please explain _____

Have you ever had any other serious illness in the past? ..... Yes ❑ No ❑

If yes, please explain _____

Are you subject to fainting spells? ..... Yes ❑ No ❑

Have you ever had radiation or chemotherapy? ..... Yes ❑ No ❑

If yes, for how long? _____

Do you currently smoke? Yes ❑ No ❑ If yes, for how long? _____ Frequency of use _____

Have you ever smoked? Yes ❑ No ❑ If yes, for how long? _____ When did you stop smoking? _____

Do you chew tobacco? Yes ❑ No ❑ If yes, for how long? _____ Frequency of use _____

Have you ever chewed tobacco? Yes ❑ No ❑ If yes, for how long? _____ When did you stop chewing? _____

Do you drink alcoholic beverages? ..... Yes ❑ No ❑

What type? _____ Frequency of use _____

Are you allergic to: Penicillin ❑ Codeine ❑ Local injected anesthetics ❑ Latex/rubber ❑ Other medications ❑ Foods/Dye ❑

If yes, what medications? _____ Other allergic concerns/items _____

Are you taking any medicine(s) including non-prescription medicine? ..... Yes ❑ No ❑

If yes, what medicine(s) are you taking? _____

Have you used the weight loss medication Fen-Phen? Yes ❑ No ❑

Are you taking any of the following herbal remedies (please circle)? Echinacea Ginkgo Biloba Garlic Ginseng

Please check any of the following which you have or may have had:

_____ Anemia	_____ Diabetes	_____ High Blood Pressure	_____ Psychiatric Treatment
_____ Arthritis	_____ Emphysema	_____ HIV	_____ Rheumatic Fever
_____ Asthma	_____ Epilepsy	_____ Kidney Disease	_____ Stomach Problems / Ulcers
_____ Bronchitis	_____ Heart Murmur	_____ Pacemaker (Heart)	_____ Stroke
_____ Cancer	_____ Heart Trouble	_____ Prosthetic Heart Valve(s)	_____ Thyroid Disease
_____ Congenital Heart Lesions	_____ Hepatitis	_____ Prosthetic Joints	_____ Tuberculosis
			_____ Venereal Disease

_____ **NONE OF THE ABOVE**

WOMEN ONLY:

Are you pregnant? ..... Yes ❑ No ❑

If yes, how many weeks? _____ How many months? _____

Are you nursing? ..... Yes ❑ No ❑

Are you taking birth control? ..... Yes ❑ No ❑

PLEASE COMPLETE AND SIGN OTHER SIDE

DENTAL HEALTH

Reason for visit: _____

When was your last dental visit? _____ Dental X-Rays _____

Have you ever had any serious problem associated with previous dental treatment? ..... Yes ❑ No ❑

If yes, please explain _____

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

Do you use a rubber tip? Yes ❑ No ❑ Do you use a proxy brush? Yes ❑ No ❑

Do your gums bleed while brushing or flossing? ..... Yes ❑ No ❑

Do your gums feel tender or swollen? ..... Yes ❑ No ❑

Have you ever been told you have gum disease? ..... Yes ❑ No ❑

Do you avoid brushing any part of your mouth or are you eating on one side because of pain? ..... Yes ❑ No ❑

If yes, what part/side? _____

Do you feel a sharp or dull pain when your teeth come in contact with:

a) Hot foods or liquid? ..... Yes ❑ No ❑

If yes, does the pain linger? ..... Yes ❑ No ❑

b) Cold foods or liquid? ..... Yes ❑ No ❑

If yes, does the pain linger? ..... Yes ❑ No ❑

c) When biting on certain foods or at certain times? ..... Yes ❑ No ❑

If yes, does the pain linger? ..... Yes ❑ No ❑

Do you clench or grind your jaws while sleeping or during the day? ..... Yes ❑ No ❑

Do your jaws ever feel tired? ..... Yes ❑ No ❑

Does your jaw joint (TMJ) ever click, pop or grind upon opening? ..... Yes ❑ No ❑

If yes, does it bother you? Yes ❑ No ❑

Have you ever had any TMJ treatment? Yes ❑ No ❑ Approximate date of treatment _____

If yes, what was performed? _____

Do you wear dentures? Yes ❑ No ❑ Do you wear partials? ..... Yes ❑ No ❑

Do you gag easily? ..... Yes ❑ No ❑

Please add anything you feel is important: _____

_____

COSMETIC DENTISTRY

Are you happy with your smile? ..... Yes ❑ No ❑

Are you happy with the color of your teeth? ..... Yes ❑ No ❑

Is there anything you would like to change about your smile, shape of teeth or tooth color? ..... Yes ❑ No ❑

If yes, what change would you like to see? _____

CONSENT

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the information required above, have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. If my health history or medicine changes, I will inform the doctor at my next appointment without fail.

I hereby grant authority to Dr. Ron J. Burgmeier to administer any treatment with patient consent, or to administer anesthetics, and to perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Authorization must be signed by the patient, or by the nearest relative in the case of a minor (under 18 of age), or when the patient is physically or mentally incapacitated.

Signed: _____ Relationship: _____

Patient or Nearest Relative

Print Name: _____

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 DR. RON BURGMEIER, DDS PA.

SIGNATURE _____ DATE _____

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

Ronald J Burgmeier DDS

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

Financial Policy

Thank you for choosing Ronald J. Burgmeier, 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 $25 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 Dr. Burgmeier's 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!