DENTAL CORNER

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2046 N. OLIVER AVE. • WICHITA, KS 67208-2503 (316)681-2425

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Employer: _____

In an emergency who should be notified? Please enter Name, Phone number & relation below:

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Employer: _____

Medical History

- [ ] *PREMEDICATE
- [ ] ALLERGY ASPIRIN
- [ ] ALLERGY CIPRO
- [ ] ALLERGY DILANTIN
- [ ] ALLERGY IBUPROFEN
- [ ] ALLERGY LACTOSE
- [ ] ALLERGY MORPHINE
- [ ] ALLERGY PENICILLIN
- [ ] ALLERGY PROZAC
- [ ] ALLERGY TYLENOL
- [ ] ANXIETY
- [ ] ASTHMA
- [ ] CANCER
- [ ] CURRENTLY PREGNANT
- [ ] EPILEPSY
- [ ] HAY FEVER
- [ ] HEART STINT
- [ ] HEPATITIS C
- [ ] HYPERTENSION
- [ ] LUPUS
- [ ] OSTEOPOROSIS
- [ ] PULMONARY FIBROSIS
- [ ] RHEUMATISM
- [ ] STOMACH PROBLEMS
- [ ] ULCERS
- [ ] ALLERGY AMONIA
- [ ] ALLERGY BACTRIM
- [ ] ALLERGY CLINDAMYCIN
- [ ] ALLERGY ERYTHROMYCIN
- [ ] ALLERGY INDOCIN
- [ ] ALLERGY LATEX
- [ ] ALLERGY MOTRIN
- [ ] ALLERGY PERCOCET
- [ ] ALLERGY SULFA
- [ ] ALLERGY VALIUM
- [ ] ARTHRITIS
- [ ] AZYTHROMIACIN
- [ ] CANCER TREATMENT
- [ ] DEPRESSION
- [ ] EXCESSIVE BLEEDING
- [ ] HEAD INJURIES
- [ ] HEART TROUBLE
- [ ] HERNIA
- [ ] JAUNDICE
- [ ] MIGRAINES
- [ ] PACEMAKER
- [ ] RADIATION TREATMENT
- [ ] SCOLIOSIS
- [ ] STROKE
- [ ] ALLERGY AMOXICILLIN
- [ ] ALLERGY BACTRUM
- [ ] ALLERGY CODEINE
- [ ] ALLERGY FRUIT
- [ ] ALLERGY IODINE
- [ ] ALLERGY LIDOCAINE
- [ ] ALLERGY NOVACAINE
- [ ] ALLERGY PERCODAN
- [ ] ALLERGY TO TRAMADOL
- [ ] ALLERGY VANCOMYCIN
- [ ] ARTIFICIAL HEART VAL
- [ ] BLOOD DISEASE
- [ ] CHEMO THERAPY
- [ ] DIABETES
- [ ] FIBROMYALIA
- [ ] HEART DISEASE
- [ ] HEPATITIS A
- [ ] HIGH BLOOD PRESSURE
- [ ] KIDNEY DISEASE
- [ ] MITRAL VALVE
- [ ] PSYCHIATRIC TREATMNT
- [ ] RESPIRATORY PROBLEMS
- [ ] SINUS PROBLEMS
- [ ] TUBERCULOSIS
- [ ] ALLERGY ANESTHETIC
- [ ] ALLERGY CEPHALEXIN
- [ ] ALLERGY DEMEROL
- [ ] ALLERGY HYDROCODONE
- [ ] ALLERGY KEFLEX
- [ ] ALLERGY LORTAB
- [ ] ALLERGY NYSTATIN
- [ ] ALLERGY PREDNISONE
- [ ] ALLERGY TRAZADONE
- [ ] ANEMIA
- [ ] ARTIFICIAL JOINTS
- [ ] BLOOD THINNERS
- [ ] COPD
- [ ] EMPHYSEMA
- [ ] GLAUCOMA
- [ ] HEART MURMUR
- [ ] HEPATITIS B
- [ ] HIV/AIDS
- [ ] LIVER DISEASE
- [ ] NERVOUS DISORDERS
- [ ] PTSD
- [ ] RHEUMATIC FEVER
- [ ] SPINAL CORD INJURY
- [ ] TUMORS

OTHER MEDICAL CONDITION OR ALLERGY NOT LISTED:

_____

Are you pregnant? ◯ Yes ◯ No

Name of Physician and Phone Number:

_____

_____

List all Medications (prescription and non-prescription) including regular doses of aspirin:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

_____

What is your immediate concern?

_____

_____

Have you been exposed to Covid in the last 14 days? ◯ Yes ◯ No

New Financial, Cancellation and No Show Policy

Effective 01/01/2023

Cancellation Policy:

In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to attend an appointment that you have scheduled. Any appointment(s) not cancelled within 48 hours (2 business days) in advance are subject to a cancellation fee.

No Show Policy:

Once an appointment has been made, that time is reserved specifically for you. A No Show is an appointment that was not cancelled in advance. No shows inconvenience other patients who need dental care.

Fees for No Show/Cancellation Policy

$25 for the first no show or cancelled appointment

$50 for the second no show or cancelled appointment

$75 for the third no show or cancelled appointment

In the event there is a third no show or cancelled appointment, Dental Corner reserves the right to terminate the doctor/patient relationship.

As part of providing you with excellent care, we will have an open and honest discussion of recommended treatment options. We understand the importance of your dental investment. Co-Payments are due in full at the time of service. For your convenience we accept cash, checks, Visa, Master card, Discover, American Express and most employers flex plan debit cards. Payment plan arrangements can be made prior to your appointment time through our third party financing provider, Care Credit. Estimated insurance benefits are based on the information made available to us from your insurance company and are NOT a guarantee of payment. Our office policy is to send out for a pre-estimate from your insurance company on any treatment over $250. Any estimated insurance payments that are not paid by insurance in 60 days will become your responsibility.

Insurance:

Filing insurance claims is a service we are happy to provide to our patients. We know dental insurance is one of the most beneficial, and one of the most misunderstood factors in dental treatment today. Dental insurance is a contract between the employer, the patient and the insurance company. It is your responsibility to know **your** insurance policy rules and benefits. We will not become involved in disputes between you and your insurance regarding non-covered charges, diagnoses, and co-pays or deductibles.

Dental Corner has the authority to charge and assess collection costs and expenses, including reasonable attorney's fees and penalties and interest for the late payment or non-payment thereof.

A service fee of 10% per annum on the unpaid balance will be charged on all accounts exceeding 60 days.

Signature:_____ Date:_____