12208 W. 87TH ST. PKWY #160
LENEXA, KS. 66215
(913) 888-0403

PATIENT INFORMATION

NAME____
LAST FIRST MI
ADDRESS____
STREET CITY STATE ZIP
HOME PHONE (__)_________________ WORK PHONE (__)_________________
CELL PHONE (__)_______________ E-MAIL ADDRESS_________________
BIRTHDATE_________ SOCIAL SECURITY NO._________________
RESPONSIBLE PARTY____
OTHER FAMILY MEMBERS IN PRACTICE_________________________
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE_________________________
PLEASE CIRCLE GENDER, MARITAL STATUS Male Female
Married, Single, Divorced, Widow(er)

RESPONSIBLE PARTY INFORMATION

NAME____ ____________ ________________
LAST FIRST MI MARITAL STATUS RELATION TO PATIENT
ADDRESS____
STREET CITY STATE ZIP
HOME PHONE(___)____________________ WORK PHONE(___)__________________
CELL PHONE(___)________________ EMAIL________________________________
SOCIAL SECURITY NO.__________________ BIRTHDATE________________________
EMPLOYER________________________ OCCUPATION___________________________
EMPLOYERS ADDRESS____
SPOUSE'S NAME________________________ EMPLOYER WK PHONE(___)_____________

FINANCE CHARGE

IF YOU DO NOT PAY THE ENTIRE BALANCE WITHIN 30 DAYS OF THE MONTHLY BILLING DATE, A FINANCE CHARGE WILL BE ADDED TO THE ACCOUNT FOR THE CURRENT MONTHLY BILLING PERIOD. IN THE CASE OF DEFAULT OF PAYMENT, I PROMISE TO PAY ANY LEGAL INTEREST ON THE BALANCE DUE, TOGETHER WITH ANY COLLECTION COSTS AND REASONABLE ATTORNEY FEES INCURRED TO COLLECT THIS ACCOUNT.

INSURANCE INFORMATION

DENTAL INSURANCE CO.____
ADDRESS____
STREET CITY STATE ZIP
POLICY HOLDER________________________________MEMBER DOB________________
GROUP NO.________________
MEMBER ID OR SS#____
PATIENTS RELATIONSHIP TO POLICY HOLDER________________________________

WE WILL FILE INSURANCE CLAIMS FOR YOU AS A COURTESY. IT IS YOUR RESPONSIBILTY TO KNOW YOUR INDIVIDUAL PLAN AND THE BENEFITS AVAILABLE TO YOU. WE DO NOT PARTICIPATE IN ANY DMO, HMO OR PPO PLANS

PLEASE BE PREPARED TO PAY YOUR CO-PAYMENTS AT THE TIME OF SERVICE, DELTA DENTAL AND BLUE CROSS INSURED'S WILL BE ASKED TO PAY FOR THEIR SERVICES AT THE TIME TREATMENT IS RENDERED AND THE INSURANCE COMPANIES WILL REIMBURSE YOU DIRECTLY. PLEASE CALL THE OFFICE PRIOR TO YOUR APPOINTMENT IF YOU HAVE ANY QUESTIONS.

I CERTIFY THAT I AM COVERED BY INSURANCE WITH THE ABOVE NAMED COMPANY AND I ASSIGN DIRECTLY TO JAMES S. CRAIG DDS, ALL THE INSURANCE BENEFITS. I AUTHOTIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THIS SIGNATURE MAY ALSO BE USED FOR ANY DEPENDENTS COVERED BY THIS POLICY.

SIGNATURE ____________________________________ DATE____________________

NAME: Last First M.I. Sex: M/F Date____________

Address: Phone:____________________

If patient is a minor, please provide parent's/guardian's name:______________________________

MEDICAL HISTORY

Physician's Name ____

Phone # ____________________ Date of last visit ___________

YOUR CURRENT PHYSICAL HEALTH IS:

Good Fair Poor

Do you use tobacco in any form? Y N
Are you taking any medications? Y N

Please list: ____

____

____

____

Do you have any implant, valves, rods or pins? Y N
Have you ever taken Phen-Fen/Redux/Pondimin? Y N
Have you ever taken prescription medication for bone loss? Y N

FOR WOMEN: Are you taking birth control pills? Y N
Are you pregnant? Y N week # ______________
Are you nursing? Y N

Have you ever had any of the following diseases or medical problems:

Y	N	Alcohol/Drug abuse	Y	N	Hepatitis
Y	N	Anemia	Y	N	Herpes/Fever Blisters
Y	N	Arthritis	Y	N	High Blood Pressure
Y	N	Artificial Joints/Valves	Y	N	HIV+/AIDS
Y	N	Asthma	Y	N	Recent Hospital stay
Y	N	Bleeding Problems	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic Fever
Y	N	Fainting/Dizzy Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Hearing Loss	Y	N	Sickle Cell Anemia
Y	N	Heart Attack	Y	N	Sinus Problems
Y	N	Heart Murmur	Y	N	STD
Y	N	Heart Surgery	Y	N	Stroke
Y	N	Hemophilia	Y	N	Ulcers

Please list any other serious medical condition(s) that you have which are not listed above: ____

Are you Allergic to any of the following?

Aspirin	Erythromycin	Metals
Codeine	Jewelry	Penicillin
Dental Anesthetics	Latex	Tetracycline

Please list any other drugs/materials that you are allergic to:

____

____

____

DENTAL HISTORY

What is the primary reason for your visit today? ________________

____

Are you currently is pain? Y N

Do you require antibiotics before dental treatment? Y N

YOUR CURRENT DENTAL HEALTH IS:

Good Fair Poor

When was the last time you had a complete evaluation? ___________

Have you ever had a serious/difficult problem associated with any previous dental work? Y N

Have you ever been informed or treated for the following dental conditions?

Y	N	Bleeding Gum	Y	N	Mobility of Teeth
Y	N	Bad Taste/Odor	Y	N	Oral Cancer/Biopsy
Y	N	Cold Sores/Ulcers	Y	N	Osseous Surgery
Y	N	Deep Cleanings/Scaling	Y	N	TMJ/TMD Joint Pain
Y	N	Gum/Periodontal Disease	Y	N	Toothbrush Abrasion
Y	N	Hot/Cold Sensitivity	Y	N	Wisdom Teeth Extraction

Do you clench or grind your teeth? Y N

Do you use tobacco in any form? Y N

Do you snore or have you been diagnosed with sleep apnea? Y N

Are you happy with the way your smile looks? Y N

If not, what would you change? ________________________________

____

____

____

I understand that the information I have given today is correct and accurate 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 herby authorize treatment of anesthesia of other medications necessary for dental treatment to be rendered by the dental staff.

____

Patient's (parent) Signature Date

James S Craig DDS, PA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review it carefully.

Our Promise
We are writing to communicate to you that we are taking seriously Federal law (HIPAA-Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do we have a Privacy policy?
The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. This has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which were developed to make sure your health information will not be shared with anyone who does not legally require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purpose of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice,

How your HEALTH INFORMATION May be Used to Provide Treatment
We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.
To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders.)

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us. We will obtain each associate’s written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse of Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete as investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention

of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To the U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to

defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose you PHI for any purposes not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you , or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes or the health information relates solely to a healthcare item or service which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information and your reason for the change

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health

information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of denial.

Accounting of Disclosure of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of Security Breach

You have the right to receive notification of a breach of your unsecured health information

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive notice of the revision.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer

Contact Officer: James S Craig, DDS
Telephone: (913)888-0403 Fax: (913)888-0643
Email: jcraigdds@kc.rr.com