# PATIENT INFORMATION

*Welcome to our office! To assist us in serving you, please complete the following confidential form.*

Patient's name _____ Preferred name _____Birth date_____

If minor, parents names _____ Cell phone _____ Work phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Emergency Contact_____Phone_____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

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

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ AIDS or HIV positive
- ❑ Alcoholism
- ❑ Allergies or hives
- ❑ Anemia or blood disorders
- ❑ Arthritis
- ❑ Artificial joint or valve
- ❑ Asthma
- ❑ Blood transfusion
- ❑ Cancer or tumor
- ❑ Diabetes Type_____
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Hay fever or sinus trouble
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Hepatitis or other liver disease
- ❑ Herpes or cold sores
- ❑ High or low blood pressure
- ❑ Kidney disease
- ❑ Nervous Disorder
- ❑ Neurologic condition
- ❑ Pacemaker
- ❑ Pregnancy, if so due date_____
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Tuberculosis or other lung problems

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Taking hormones or contraceptives
- ❑ Other:_____
  _____

Do you have Migraines or frequent headaches?
Explain:_____

_____

Name of your physician:_____

Do you have any disease, condition, or problem not listed above? _____

_____

Please add anything else you would like us to know about: _____

_____

Signature of patient (or parent) _____ Date _____

# ***Limited Dental Warranty***

Our practice is proud of the dentistry that we provide for you and your family. Our goal is not just to correct any dental problems you may have, but also to show you how to prevent dental disease in the future and to save you time and unnecessary expense. The long-term success of the treatment we provide depends on the care of your teeth and gums at home and keeping all recommended professional cleanings within the recommended timeframes. These appointments include periodic examinations by the dentist of the teeth, gums, bone, oral cavity, throat, muscles of the head and neck, oral cancer screenings, x-rays, cleanings, and fluoride treatments. The products we recommend for you and the frequency of visits depends on your individual condition. **Visits may be every 2, 3, 4, or 6 months, depending on your oral health. With that in mind, we offer the following limited dental warranties.**

## _____*Composite (Tooth Colored) Fillings*

If a composite filling is the *recommended* treatment of choice, we will replace or repair it in the event of a failure for a period of 2 years. Composite restorations done as a *compromised* form of treatment (instead of a crown, inlay, onlay, or veneer) are not covered under this warranty. If the *recommended* restoration itself breaks or fractures within 1 year and requires a crown or onlay, we will credit the initial cost of the filling towards the crown. You must keep up with the *prescribed* recall (exam and cleaning) appointments and x-rays to allow us to properly monitor and maintain the restorations or this warranty is null and void (minimum recall every 6 months).

## _____*Root Canals*

Root canal treatment is 96% successful. They do occasionally fail. If you lose your tooth within 1 year due to *failure of the root canal*, we will credit the fee for the root canal towards the fee for a replacement tooth. You must keep up with the *prescribed* recall (exam) appointments and x-rays to allow us to properly monitor and maintain the restorations or this warranty is null and void (minimum recall every 6 months).

## _____*Crowns, Bridges, Inlays, Onlays, and Porcelain Veneers*

We will warranty laboratory made restorations for a *full 3 years*. We will replace or repair them at no charge during the three-year period if the *restorations* break, decay, or loosen with normal use. If the laboratory restoration breaks with normal use after 3 years, up to a maximum of 5 years, you will only be responsible for the lab fee. This does not include accidents that could also break normal, healthy teeth. Breakage or fracture of the *natural tooth* supporting a restoration is not covered by this warranty. You must keep up with the *prescribed* recall (exam) appointments and x-rays to allow us to properly monitor and maintain the restorations or this warranty is null and void (minimum recall every 6 months).

## _____*Dentures and Partials*

We will warranty dentures and partials for a period of 3 *years* if a tooth or the denture breaks under normal use. After 3 years, up to a maximum of 5 years, if your prosthesis breaks with normal use you will only pay the lab fee. Accidents such as dropping your denture are not covered. Due to the nature of dentures, we cannot guarantee your comfort or ability to accommodate these artificial replacements. You must keep up with the *prescribed* recall (exam) appointments and x-rays to allow us to properly monitor and maintain the restorations or this warranty is null and void (minimum recall every 6 months).

## _____*Note*

As you can see, we are confident in the durability of the treatment we prescribe for you. The primary key to your long-term success is spending time on your home care: brushing, flossing, using fluoride and other prescribed products. Another key to success is regular professional exams, cleanings, x-ray films and fluoride treatments. This warranty does not cover accidents that cause damage to the teeth or dental prosthesis. Help us to help you maintain your dental health for a lifetime.

**I have read and agree to the above terms and conditions as stated. I also understand that these terms can be changed, modified at the discretion of William Ledford, D.D.S. or Dr. Ledford's staff without notice to the patient or responsible party.**

_____

PATIENT / GUARDIAN SIGNATURE Date

**William D. Ledford, D.D.S.**
**1236 W 103Rd St**
**Kansas City, MO 64114**
**816-941-0980**

We thank you for selecting us for your dental care team. We strive to make your relationship with our office a pleasant one. We believe that services to you are at its best when there is complete understanding and mutual cooperation between the patient and our staff.

We have several payment options. We accept Visa, MasterCard, Discover and American express. Financing through Care Credit is also available. If you are interested in Care Credit, please ask for more information.

**Co-Insurance and deductibles are due at the time of service.**

Although we do our utmost to assist you in obtaining benefits under your plan; you should be aware that your insurance is an agreement between you and your insurance company. We cannot be responsible for limitations set by your insurance company. Therefore, when given your out of pocket cost for treatment, it is **ONLY an ESTIMATE**. Until your claim is processed with your insurance company, there is no guarantee of benefits or co-insurance amounts. Any amount not covered by insurance is patient responsibility.

It has always been our contention that time is valuable. We have one theory about scheduling: you deserve our undivided attention. For this reason, we do not double book like other practices**.**

**Failure to provide our office with a 48 hour notice of cancellation will result in a *$35.00* missed appointment fee, or 15% of the billable charges, whichever is greater, this is payable by the patient or responsible party.**

Your satisfaction is the utmost importance in patient relations. If you have any questions or concerns, please feel free to discuss the matter with us.

**I have read and agree to the above terms and conditions as stated. I also understand that these terms can be changed, modified at the discretion of William Ledford, D.D.S. or Dr. Ledford's staff without notice to the patient or responsible party.**

Patient/Responsible Party Signature Date

WILLIAM D. LEDFORD, D.D.S

**PATIENT CONSENT/ACKNOWLEDGMENT FORM**

By signing below, you consent to the use and disclosure of your protected health information by William D. Ledford, D.D.S., our staff, and our business associations for treatment, payment and healthcare operations. For a more detailed description of uses and disclosures for these purposes, please review our notice of information practices “notice”. You have the right to review the notice prior to signing this consent. The terms of this notice may change. If the terms do change, you may obtain a revised notice by simply contacting this office at (816) 941-0980 and request a revised notice. We will also post and revised notice in the office. You have the right to request that we restrict our uses or disclosure of your protected health information, which we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected healthcare information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your protected health information. This form is used to obtain acknowledgement of receipt of OUR NOTICE of privacy practices or to document our good faith effort to obtain that acknowledgment.

I have reviewed, understand, and agree to the content of the notice of privacy.

PATIENT NAME: _____
PATIENT SIGNATURE: _____DATE:_____

Please specify the exact reason why the patient chose not to sign the consent/acknowledgement of notice of privacy.
_____
_____
_____