5830 Nall Ave
Mission, KS 66202
913-432-3112

KREMERS, FORBES
AND ASSOCIATES DDS

6852 Silverheel St
Shawnee, KS 66226
913-721-6477

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Initial: _____

I prefer to be called: _____ ☐ Male ☐ Female Date of Birth___/___/_____

Home Phone Number: _____ Social Security Number: _____-_____-_____

Address: _____ City: _____ State_____ Zip: _____

Employer: _____ Email Address: _____

Work Phone Number: _____ Cell Number: _____

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

ACCOUNT INFORMATION

Responsible Party: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____/___/_____ Home #: _____ Work #: _____

INSURANCE INFORMATION-PRIMARY

Insurance Company: _____ Claims Phone Number: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Relationship to Patient: _____ Birthdate: _____

Employer: _____ Insurance ID/ S.S # _____ Group #: _____

INSURANCE INFORMATION- SECONDARY

Insurance Company: _____ Claims Phone Number: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Relationship to Patient: _____ Birthdate: _____

Employer: _____ Insurance ID/ S.S # _____ Group #: _____

IN CASE OF EMERGENCY

Name: _____ Relationship to Patient: _____

Home Phone: _____ Work #: _____ Cell #: _____

Authorization and Financial Agreement

I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to a third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I also understand that any fees quoted to me by the dental office are only co-payment estimations and that the office will not know the final number until the insurance pays. I agree to the responsible for payment of all services rendered on my behalf or my dependents. I also am aware that if my bill is not paid in a timely fashion, a late fee of 10% or a billing charge may be added. I agree to contact the office at least 48 hours in advance of my scheduled appointment time, to avoid any last minute cancellation fees. Broken appointments will be charged $50.

HIPAA- Notice of Privacy Practices

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about or privacy practices, our legal duties, and your rights concerning your Health Information. We must follow the privacy practices that are described in this Notice while it is in effect This Notice takes effect 4/13/03 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, inlcuding health information we created or received before we made the changes. Before we make a signficiant change in our privacy practices, we will change this Notice and make the new notice available upon request. You may request a copy of our Notice at any time. For more infromation about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and Improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. **Your Authorization**: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give give us written authorizations to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health infromation for any reason except those described in this Notice. **To Your Family and Friends**: We must disclose your health information to you, as described in the Patient Rights secion of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your helathcare, but only if you agree that we may do so. **Persons Involved In Care**: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health infromation that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or othersimilar forms of health information. **Marketing Health-Related Servies:** We will not use your health information for marketing communications without your written authorization. **Required by Law:** We may use or disclose your health information when we are required to do so by law. **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Signature_____ Date _____

William Kremers, DDS
Anthony Garcia, DDS

KREMERS, FORBES AND ASSOCIATES DDS

Matthew Forbes, DDS
Drew Nuckolls, DDS

Dental History

Former Dentist: _____ Date of last exam: _____

Reason for Today's visit: _____

What if anything, would you change about your smile? _____

Please circle if you are currently or have ever had problems with any of the following:

Sensitivity to Hot/Cold	Bleeding/Painful Gums	Periodontal Treatment
Sensitivity to Sweets	Receding Gums	Orthodontic Treatment
Sensitivity to Biting/ Chewing	Food Collecting between teeth	Loose/Broken teeth
Bad Breath/ Bad Taste	Jaw Clicking, Popping, or Pain	Mouth Sores
Clenching Teeth/Grinding Teeth		

Do you snore when you sleep?	Yes	No
Have you ever been diagnosed with sleep apnea?	Yes	No
Have you ever wanted your teeth to be straighter?	Yes	No
Have you ever wanted your teeth to be whiter?	Yes	No
Do you have any old fillings or dental work you are unhappy with?	Yes	No
Are you anxious about receiving dental treatment?	Yes	No

If yes, what are your biggest concerns? _____

Is there anything you would like to let us know (positive or negative) about your past dental experiences that may help us provide a better experience for you. _____

I have received a copy of the authorization and financial agreement and HIPAA privacy practices.

Signature: _____ Date: _____

Time 11:19 AM | William R. Kremers, D.D.S. | Date 8/4/2021

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____