Hrencher Dental

General and Cosmetic Dentistry

Acknowledgment of Receipt: I understand the **Notice of Privacy Practices** and have received a copy for my records or I was offered to receive a copy but declined knowing I can obtain a copy at any time. I freely and voluntarily consent to participate in the services provided by Austin Hrencher D.D.S, PA.

_____

Patient name (please print)

_____ _____

Patient/Parent/Guardian signature Date

Hrencher Dental

1. Your dental health is important to you and to us. We strive to give you the best dental care we can, but we can only do so much. After you leave the clinic, we expect you to follow any directions that have been given to you. It is important to have a regular dental check up and if treatment is recommended or needed, we expect you to follow up on keeping appointments.
2. **CANCEL AND NO SHOW AGREEMENT:**
   The following policies explain our position regarding cancellations and broken appointments for dental visits.
   a. We require advance notice (24 hrs) in the event of a cancellation.
   b. When you fail to show as scheduled, several people are affected. You, the patient, do not receive the treatment you need; the dental health professionals who have set up a space and supplies for your treatment; and another patient, who could have been scheduled and received treatment during your time.

BECAUSE KEEPING APPOINTMENTS FOR TREATMENT IS VITAL TO YOUR DENTAL HEALTH, IF YOU HAVE A HISTORY OF BROKEN APPOINTMENTS WITHOUT NOTICE, YOU WILL BE DISCHARGED FROM THE PRACTICE.

3. **When to be here:**
   It is important to be at your dental appointment on time. To keep everyone on task, you have been appointed in a tight schedule. If you are more than 10 minutes late, you may have to be rescheduled or wait until the next available time. For our office staff, we will work to see you at the appointed time. However, dental emergencies may arise and cause us to be late. If that should happen, we apologize for any inconvenience but we hope that you would understand, knowing that emergencies could also happen to you.

   Please sign below as acknowledgment of these polices.

Signature_____ Date_____

208 Ross Blvd, Suite B • Dodge City, KS 67801
(620) 225-5682 • (800) 886-5682

Name _____ _____ Age _____ Birthdate _____
(first, middle initial, last) (wishes to be called)

SS Security# _____ ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____
(number, apt.#, street, city, state, zip)

Home Phone _____ Work Phone _____ Spouse Work Phone _____

Cell Phone _____ Message Phone _____ Email _____

Employer _____ Address _____ Phone _____

Insurance Plan _____ Direct enrolled or through employer? _____

Spouse/Parent/Guardian Name _____ Birthdate _____

Spouse's Employer _____ SS# _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell Best time to reach you? _____ By Text? Yes ☐ No ☐

In the event of an emergency, whom should we contact? _____

Relationship _____ Work# _____ Home# _____

Whom may we thank for referring you? ☐ Phone Book ☐ Physician ☐ Friend ☐ Family ☐ Other _____

MEDICAL HISTORY

Are you under a physician's care now? ☐ Yes ☐ No ☐ If so, why? _____

Physician's Name _____ Phone# _____

Are you taking any medications now? ☐ No Medication Purpose

_____ _____

_____ _____

_____ _____

Have you ever been on bisphosphonate, cancer or osteoporosis medications? _____

Do you require pre-medication? _____ Do you take daily aspirin or blood thinner? _____

Have you been hospitalized in the last two years? ☐ Yes ☐ No Why? _____

ARE YOU ALLERGIC TO: ☐ Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other _____ ☐ None

HAVE YOU EVER TESTED POSITIVE FOR HEPATITIS, HIV, OR ANY OTHER CONTAGIOUS DIESASE? ☐ Yes ☐ No Other _____

Have you ever had:	Y	N		Y	N		Y	N
Heart disease	☐	☐	Epilepsy	☐	☐	*Rheumatic Fever	☐	☐
Congenital heart Lesions	☐	☐	Cancer/Tumor (circle one)	☐	☐	Asthma/Hay Fever (circle one)	☐	☐
*Heart Murmur	☐	☐	Prolonged Bleeding	☐	☐	Sinus Trouble	☐	☐
Heart Attack	☐	☐	Diabetes	☐	☐	Stroke	☐	☐
Heart Surgery	☐	☐	Ulcers	☐	☐	Tuberculosis/Lung Disease	☐	☐
*Mitral Valve Prolapse	☐	☐	Jaundice	☐	☐	Glaucoma	☐	☐
*Heart Pace Maker	☐	☐	*Joint Replacement Surgery	☐	☐	Drug Abuse/Dependency	☐	☐
Abnormal Blood Pressure	☐	☐	Date _____			Do you smoke/chew tobacco	☐	☐
Are you pregnant?	☐	☐	If yes, due date _____					

***If yes to any of the starred conditions, you may require premedication prior to dental treatment.**

Have you ever had any other serious illness not checked above? ☐Yes. ☐No _____

_____

I will pay for my services by: ☐ cash ☐ check ☐ credit card ☐ care credit/other _____

I understand I am responsible for payment in full at time of service. This payment is not based on any insurance coverage I may have. I hereby consent to the treatment agreed upon, to the taking of dental x-rays for diagnostic purposes, and to the use of local anesthetics or relaxants for completing the treatment. Unless specifically noted, I grant permission to video tape or to take photographs of my mouth to be used without revealing my identity for the furthering of dental knowledge and education.

UNLESS WE RECEIVE A NOTIFICATION ON THE PRIOR BUSINESS DAY, THERE WILL BE A $100 FEE FOR MISSED APPOINTMENTS. THERE WILL BE A $30 FEE FOR ANY RETURNED CHECKS.

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff before the next appointment.

X _____ _____
Patient's Signature (or parent/guardian) Date