Grant D. Ringler, DDS
Justin L. Barnhart, DDS
Melissa C. Barnhart, DDS

3008 Garden Grove Parkway
Hutchinson, KS 67502
620.669.0835 Office
620.669.0559 Home
888.OPN.WIDE

Welcome to The Ultimate Dental Experience

Patient Information:

Name: _____ Birthdate: ___/___/___
First Middle Initial Last

Preferred Name: _____ Month/Year of Last Dental Exam: _____

Female: _____ Male: _____ Single: _____ Married: _____ Other: _____ Child: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell #: _____

E-Mail Address:

Employer: _____ Work #: _____

Patient's Social Security #: _____

○ I would NOT like to receive text message appointment reminders from Dr Grant Ringler
(Only phone call reminders)

Responsible Party (If different than patient): _____

Relationship to Patient: _____ Contact #: _____

Do you have family members who come here? YES NO

Do you have family members who need appts.? YES NO

How did you hear about our office: _____

Rate your anxiety level with dental visits:

0	1	2	3	4	5	6	7	8	9	10
None										High

Reason for your visit:

[ ] Routine Exam/Cleaning
[ ] Second Opinion
[ ] Implant Solutions
[ ] Tooth Extraction
[ ] Sedation Dentistry
[ ] Teeth Whitening
[ ] Six Month Smiles
[ ] Toothache
[ ] Cosmetic Solutions
[ ] Need Dental Work
[ ] Children's Dentistry

Other: _____

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Dental Insurance Information

Patient Name: _____ Birth Date: ____/____/____

Responsible Party: _____ Phone #: _____

Relationship to Patient: _____

This is the first time I have used this dental plan. YES NO

Primary Insurance

Subscriber Name: _____

Subscriber Address: _____

Subscriber Social Security #: _____ Birth Date: ____/____/____

Employer: _____

Insurance Company: _____

ID #: _____ Group #: _____

Secondary Insurance

Subscriber Name: _____

Subscriber Address: _____

Subscriber Social Security #: _____ Birth Date: ____/____/____

Employer: _____

Insurance Company: _____

ID #: _____ Group #: _____

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Dental Health History

Today's Date: _____

Patient Name: _____ Birthdate: ____/____/____

Dental History

Reason for Today's Visit: _____ Former Dentist: _____

Check [X] if you have had problems with any of the following: Date of last dental care _____

[ ] Bad Breath [ ] Grinding Teeth [ ] Bleeding Gums [ ] Clicking/popping jaw
[ ] Loose Teeth [ ] Broken fillings [ ] Periodontal Treatment [ ] Sensitivity to cold
[ ] Other _____

How often do you floss? _____ How often do you brush? _____

Medical History

Primary Care Physician: _____

Are you under a physician's care now? [ ] Yes [ ] No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? [ ] Yes [ ] No If yes, please explain: _____

Have you ever had any serious head or neck injury? [ ] Yes [ ] No If yes, please explain: _____

Do you require Pre-Med antibiotics before dental treatment? [ ] Yes [ ] No If yes, why: _____

Do you use tobacco? [ ] Yes [ ] No If yes: [ ] Chewing tobacco [ ] Smoke

Do you use controlled substances? [ ] Yes [ ] No

Women: Are you [ ] Pregnant ? [ ] Trying to get pregnant? [ ] Nursing? [ ] Taking oral contraceptives?

Are you allergic to any of the following?

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Sulfa Drugs [ ] Latex/Iodine [ ] Local Anesthetics
[ ] Other _____

_____

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

[ ] Anemia
[ ] Arthritis
[ ] Artificial Heart Valves
[ ] Artificial/Replacement Joints
[ ] Asthma
[ ] Back Problems
[ ] Blood Disease
[ ] Cancer
[ ] Circulatory Problems
[ ] Chemical Dependency
[ ] Chemotherapy
[ ] Cold Sores
[ ] Cough, Persistent
[ ] Cortisone Treatment
[ ] Diabetes
[ ] Epilepsy
[ ] Emphysema/Respiratory Disorder
[ ] Fainting/Dizziness
[ ] Gastro-Esophageal Reflux Disease
[ ] Glaucoma
[ ] Headaches
[ ] Heart Problems
[ ] Heart Murmer
[ ] Hemophilia/Abnormal Bleeding
[ ] Hyper/Hypothyroid
[ ] Hepatitis A/B/C
[ ] High/Low Blood Pressure
[ ] HIV/AIDs
[ ] Jaw Pain
[ ] Kidney Disease
[ ] Liver Disease
[ ] Mitral Valve Prolapse
[ ] Pacemaker
[ ] Previous Biopsies
[ ] Radiation Treatment
[ ] Rheumatic Fever
[ ] Sinus Trouble
[ ] Tuberculosis
[ ] Osteoporosis

List any medications you are currently taking: _____

_____

_____

In case of emergency, notify: _____ Phone #. _____

I authorize the dentist to release any information including diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I have answered the above health/medical form accurately and to the best of my ability. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment at time of service rendered on my behalf or my dependents.

Patient Signature: _____ Date: _____

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Serving our patients better with dental concerns & interests including whitening, straightening teeth, grinding, clenching, missing teeth, dental solutions, cosmetic solutions, fears and anti-aging is our goal. Thank you for taking time to let us know the ways we can serve you more thoroughly.

Brushing and Flossing

Are you currently using only a manual toothbrush?	YES	NO
Do you feel you could do a better job of cleaning between your teeth?	YES	NO
Are your teeth sensitive?	YES	NO
Do your gum tissues bleed?	YES	NO
Is the prevention of periodontitis or gingivitis (gum disease) a concern?	YES	NO

Clenching and Grinding

Do you grind your teeth?	YES	NO
Do you clench your teeth?	YES	NO
Do your teeth show signs of wear?	YES	NO
Are you bothered by persistent headaches or migraine attacks?	YES	NO

Teeth Whitening

Are you happy with your present tooth shade?	YES	NO
Do you see others with healthy, white teeth and wish your teeth looked the same?	YES	NO
Have you noticed your teeth becoming increasingly yellow?	YES	NO
Do you entertain habits that cause your teeth to darken? ex: Wine, Coffee	YES	NO
Have you considered professional teeth whitening procedures?	YES	NO
Are you interested in dental anti-aging improvements?	YES	NO

Cosmetic Improvements

Are you concerned about gaps, spaces, over-crowding and misaligned teeth?	YES	NO
Have you considered cosmetic improvements such as crowns?	YES	NO

Implants

Are you bothered and concerned about missing teeth?	YES	NO
Have you considered dental implants for a solution?	YES	NO

6 Months Smiles

Have you worn braces in the past and now notice shifting of your teeth?	YES	NO
Do you have crowding and spaces that bother you?	YES	NO
Does the appearance of your teeth keep you from smiling?	YES	NO
Do you want to know more about 6 Month Smiles?	YES	NO

Sedation Dentistry

Do fears of dentistry keep you from taking care of needed dental issues?	YES	NO
Have you had a bad dental experience in the past?	YES	NO
Are you interested in learning more about conscious and deep sedation methods?	YES	NO

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____ Telephone: _____

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

Section B: To the Patient - Please Read The Following Statements Carefully

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry on treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: The Health Insurance Portability & Accountability Act of 1996 is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required to maintain the privacy of our health information how it is used and disclosed.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, if we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at anytime through designated contact personnel.

Contact personnel:
Mel Whitmore
620-669-0835

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

The completed Consent will be maintained in the patients record.
You are entitled to a copy of this Consent after you sign it.

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Financial Policy and Consent for Services at Grant D. Ringler, DDS

We would like to thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our financial policy and consent for services.

Patients with Insurance:
Please have your correct insurance card available for us to photocopy so we will be able to confirm your dental benefit coverage. We will provide you with an estimate for your co-payment amount and expect that estimated portion to be paid today. Any delay in obtaining sufficient information may result in consultation and/or treatment to be rescheduled. If we cannot confirm your dental benefits, we will ask for full payment. Once provided with the correct information, we can then file the insurance for your reimbursement. We would be happy to complete your insurance form in an acceptable way that receives the best return for you. However, this does not absolve the patient of the full responsibility for the charges. The estimate provided by our office is to be considered as a guideline only until the final insurance payment is received and your account reconciled.

Patients without Insurance:
If you currently do not have insurance, we can provide you with an estimate of the charges prior to our initial consultation by the doctor. The estimate may vary depending upon the final diagnosis and type of treatment rendered. The full balance is expected to be paid at time of service.

Financing is available for extensive dental treatment to those who qualify. We will be happy to consult with you on this method of payment. In the event a legal suit or should outside collections become necessary to enforce payment of the account, the patient agrees to pay for all collection fees and/or attorney's fees in addition to court cost as may be deemed reasonable.

To accommodate you, we accept the following methods of payment: Cash, Check, Master Card, Visa, Discover, American Express, Care Credit, and Lending Club.

Consent of Service
There is no assurance of success that has been or can be given in dental treatment. There is always the possibility that further treatment may be necessary which may result in additional charges. In signing below you acknowledge full responsibility for the payment of all necessary services on the date treatment is started.

I understand that a specific amount of time is allotted for my visit. I understand if I need to cancel my appointment, I need to inform the office with **48-hour notice or a $65 cancellation charge may be applied**.

I have read, understood, and agree to the above financial policy and consent of services.

_____ Date: _____

Signature of Patient and/or Responsible Party