Steven L. Wilson, D.D.S., LLC
210 E. 30th Ave.
Ste. 140
Hutchinson, KS 67502
(620)665-5200

Welcome to our periodontal practice. If you are from out of town, or not familiar with Hutchinson, you may refer to the "Map" tab to assist you with directions. Please, take your time to thoroughly complete these forms and bring them with you to your appointment.

It would be helpful if you could arrive 10 minutes before your scheduled appointment time, so we can complete your registration. Our mission is to provide quality periodontal therapy in a caring atmosphere.

Your initial consultation appointment will be approximately one hour in length. This is necessary to provide a complete periodontal evaluation and establish recommendations for future treatment. Each patient presents with a different type and amount of pathology that will need to be treated. It's impossible to determine ahead of time what those needs might be. Once we've completed the examination you will know in detail what needs to be accomplished and how the treatment can be completed.

Because of our commitment in reserving this time for you, we ask that you make a sincere effort in keeping this appointment. If you must reschedule an appointment with us, please notify us at least twenty-four hours prior to your scheduled time. There will be a $99.00 charge made for the broken appointments.

We ask that you be prepared to pay for your consultation ($109.00) at the time of your visit. If your insurance makes a payment, that amount will be applied to any future treatment or refunded if no treatment is prescribed. Please be aware that if you have had an exam or consultation with another dentist within the last 6 months, your insurance may not cover this first visit to my office. You will need to check with your insurance if you are not sure about your coverage. All future treatment that we recommend will be predetermined with your insurance and you will only be asked to pay the amount determined by your insurance at those visits. Payment arrangements can be made if needed or we will be happy to help you apply with Care Credit for large amounts.

We simply wanted you to have this information regarding our policy pertaining to appointments not honored.

If you have questions, please call 620-665-5200. We look forward to meeting you and working together to address your dental health needs.

Sincerely,

Dr. Steven L. Wilson and Team

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Please fill in all blanks and make corrections where needed and sign where requested.

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Birth Date: _____ Gender: _____ Family Status: _____

Social Security #: _____ Phone (Home): _____

Phone (Cell): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Email Address: _____

Is E-mail a good way to contact you? Yes ☐ No ☐

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

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

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Information

Date of Last Dental Visit: _____Reason for this visit: _____

Were X-rays taken? Yes ☐ No ☐

Did you make regular visits to the dentist before then? Yes ☐ No ☐

Are you aware of a dental problem? Yes ☐ No ☐ Please Explain: _____

What do you feel is the present condition of your mouth? _____

Do your gums bleed? Yes ☐ No ☐ Have you ever been told you have gum disease? Yes ☐ No ☐

Does food chronically collect between your teeth? Yes ☐ No ☐

Are your teeth acutely sensitive to: Sweet ☐ Cold ☐ Heat ☐ Pressure ☐ No ☐

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

Are you interested in preventing further dental problems by having regular dental examinations and care?

Yes ☐ No ☐ _____

Is there anything else that would be valuable for me to know? _____

Has any dental treatment been recommended to you that has not been done? _____

_____

Health Information

Have you ever had any of the following? Please check those that apply

☐ AIDS
☐ Alcohol or Drug Dependency
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Arthritis
☐ Asthma
☐ Bone Disease / Osteoporosis
☐ Chemotherapy
☐ Diabetes
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ HIV Positive
☐ Neurological Disorder
☐ Organ Transplant
☐ Pregnancy
Due date:_____
☐ Taking Birth Control Pills
☐ Psychiatric Care
☐ Radiation Therapy
☐ Severe Anxiety with Dentistry
☐ Sinus Trouble
☐ Stroke
☐ Thyroid Problem
☐ Tobacco Usage
☐ Tuberculosis
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Local Anesthetic Allergy
☐ Allergy to any metals
☐ Latex Allergy
Allergic Other:
☐ _____
☐ _____
☐ _____

Are you taking or have you taken?

☐ Fosamax
☐ Actonel
☐ Boniva
☐ Aredia
☐ Zometa
☐ Coumadin
☐ Blood Thinners
☐ _____Steroid

List all medications or drugs and dosages that you are presently taking: _____

_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Dental Insurance Information Only
(Please Bring Your Card with You)

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last, First, MI)

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
(Street, City, State, Zip Code)

Insured's Employer Name: _____

Address: _____
(Street, City, State, Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last, First, MI)

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
(Street, City, State, Zip Code)

Insured's Employer Name: _____

Address: _____
(Street, City, State, Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services by Steven L. Wilson, DDS

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

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 our 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 April 14, 2003, 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 the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant 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 information about our privacy practices, or for 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 or 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 of healthcare operations, you may give us written authorization to use your health information of to disclose it to anyone for any purpose. If you give us an 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 you health information for any reason except those described in this Notice.

To Your Family and Friends: We may disclose health information to notify, as described in the Patients Rights section 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 healthcare, 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, you personal representative or another person responsible for your care, of you 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 judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment 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 other similar forms of health information.

Marketing Health-Related Services: 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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page. $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to the additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means of location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, Please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information of in response to a request you made to amend or restrict the use or disclosure of your health information of to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **Steven L. Wilson, DDS, 210 E. 30th, Suite 140, Hutchinson, KS 67502 Phone: (620) 665-5200**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Signature (or parent signature for child)

_____

Date

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ For Office Use Only ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____

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