MEDICAL HISTORY

CosMedic DENTISTRY
RP McGraw DDS LLC
Natural Smiles for Healthy Lives

PO Box 723
417 Northland Drive
Cameron, MO 64429
816-632-6700
www.CosMedicDentistry.com

PATIENT NAME_____

BIRTH DATE_____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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 a serious head or neck injury? ❍ Yes ❍ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ❍ Yes ❍ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❍ Yes ❍ No If yes, please explain: _____

Are you on a special diet? ❍ Yes ❍ No If yes, please explain: _____

Do you use tobacco? ❍ Yes ❍ No If yes, please explain: _____

Do you use controlled substances? ❍ Yes ❍ No If yes, please explain: _____

Women: Are you
Pregnant/Trying to get pregnant? ❍ Yes ❍ No Taking oral contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

Are you allergic to any of the following? ❍ Asprin ❍ Penicillin ❍ Codeine ❍ Local Anesthetics ❍ Acrylic ❍ Metal ❍ Latex ❍ Sulfa Drugs
❍ Other If yes, please explain: _____

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 Problem ❍ 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

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 _____ DATE _____

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CONSENT TO DIAGNOSIS, TREATMENT, SURGERY AND/OR THE ADMINISTRATION OF ANESTHESIA

PATIENT NAME_____

BIRTH DATE_____

DATE_____TIME_____ AM / PM

To: Doctor R. P. McGraw

I, the undersigned, having requested that you perform diagnosis, treatment, surgery, and/or administer anesthesia on

_____

(Name of patient)

do hereby give full and unconditional authority to proceed with diagnosis, treatment, surgery, and/or the administration of anesthesia as your judgment indicates. Further, if in the course of the contemplated operation or treatment, a different or more extensive operation or treatment, in your judgment, is required you are fully authorized to proceed therewith.

The undersigned is obligated and bound to hold you and/or your associates harmless from any and all consequences for such diagnosis, treatment, surgery, and/or the administration of anesthesia, provided that your duties are performed to ordinary standards of care and to the best of your ability. If these standards have been met, you and each of your associates are hereby fully released from any and all claims and demands whatsoever which might arise, grow out of, or be incident to such diagnosis, treatment, surgery, and/or the administration of anesthesia.

Furthermore, I am aware of the fact and fully understand that no medical or dental procedure is without risks, possible alternative methods of treatment, or the possibility of complications. I also hereby agree that I will not permit any work to be done until such time as reasonable explanations of the risks, possible alternative methods of treatment and possible complications are made to my satisfaction. I also clearly understand that such explanations may not be, or not need to be totally or fully comprehensive, depending upon my wishes.

I also agree that presentation of the undersigned to this office for any diagnosis, treatment, surgery, and/or the administration of anesthesia shall constitute full and unconditionally binding agreement to all of the terms of this consent form, and that this consent shall be binding until I specifically rescind this authorization in writing. I further acknowledge and agree that no guarantee of assurance has been or will be made as to any possible results that may be obtained, and that any assurances or representation that I have received do not constitute warranties or guarantees.

I certify that I have read and fully understand the above consent form, that any necessary explanations of this form and the procedures anticipated to be performed have been made to me, and that all blanks or statements requiring insertion or completion were filled in before I affixed my signature.

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SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

WITNESS _____ DATE _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME_____

DATE_____

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone: E-mail: _____

Patient Number: _____ Social Security Number: _____

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 out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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 any time by contacting:

Contact Officer: Lana Kirschman **Telephone:** 816-632-6700 Fax: 816-632-6702 **E-mail:** hippa@dentistryanddentures.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed consent in the patient's chart.

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 heath care operations.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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OFFICE FINANCIAL POLICY AND AGREEMENT

PATIENT NAME_____

DATE_____

In this office we work hard to control our costs and keep the price for our services manageable and under control. In order to accomplish this, one of the things we must insist on is that payment be made at the time services are provided, unless other specific, written arrangements have been made. We are not able to provide an open account for the payment of services, so if you are not able to pay for the services we provide, please advise us of this before we provide treatment rather than after the fact. Missed appointments increase the cost of all healthcare for everyone. Missed, no-show appointments or appointments cancelled without at least 24 hours notice incur a minimum $75/ per hour or fractional hour, missed appointment fee, which cannot be charged to your insurance and which is due and payable immediately. We do not offer refunds or accept returns for any custom dental appliance or service.

We'll happily help you process and file your dental insurance, but any estimate we make of what your insurance policy may cover is just that, a good faith estimate. Your dental insurance company has a contractual relationship with your employer (or spouse's or parent's employer), to which we are typically not a party. When we provide services that may be covered by insurance, we'll promptly, and at no additional charge, take our own time and materials to complete your claim form information to the best of our ability, and to the same standards that we have processed insurance information for over 20 years. We'll submit it promptly to your insurance company unless you advise us that you'd prefer to pick up the form and submit it yourself. The financial responsibility for the services we provide however, is yours, and yours alone. How much and when your insurance company may pay for the services we provide to you, is of course, not something we have any control over. If we have accepted assignment of your insurance benefits, payment for our estimate of the charges your insurance company will not pay, is due at the time the services are provided unless other specific written arrangements are made. Any balance remaining on your account after your insurance has paid their share of your charges, is entirely and without exception, your responsibility to pay. Any balance, whether potentially covered by insurance or not, that is not paid within 30 days of the delivery of services, will incur a service charge of 18% per anum, applied until payment is received. Service charges are not something that your insurance company will pay, so in order to avoid additional charges associated with carrying accounts, you may prefer to pay for our services yourself and choose to receive the payment from your insurance company directly. Should any balance remain unpaid for any reason however, you agree to pay the costs associated with the collection of that balance, including, but not limited to reasonable attorney's fees and accrued interest or service charges.

We have found that for extensive treatment, Care Credit™ is the best option for our patients, allowing them reasonable interest rates and good payment flexibility (please ask us for more information). A number of our patients have found that it is very effective to take advantage of low home equity mortgage rates to finance extensive treatment, and may offer advantages of tax deductibility of interest on such loans (consult your tax adviser for details).

By signing below, you acknowledge that you have read and agree to all the terms of the financial policy of this office, and that you, or the person identified, and whose signature appears as the "Financially Responsible Party" accept responsibility for all charges incurred on your behalf and will pay them within the terms of this policy.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PRINTED NAME (if other than patient)_____

PATIENT'S NAME (Please Print)_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED, 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 or healthcare operations, you may give us written authorization to use your health information or 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 your health information 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 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, 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 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 authorized 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 $1.00 for each page, 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 period, 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 or disclosure of your health information. We are not required to agree to these 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 or 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 Web site 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 or in response to a request you made to amend or restrict the use or disclosure of your health information or 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 and Human 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.

Contact Officer: Lana Kirschman **Telephone:** 816-632-6700 Fax: 816-632-6702 **E-mail:** hippa@dentistryanddentures.com

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, (Please print name) _____ have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement 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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FAMILY HISTORY

PATIENT NAME_____

DATE_____

FAMILY HISTORY

Please mark the box or boxes if any of your family members has had major reoccurring medical problems or a medical problem that was the cause of death.

YOUR MOTHER:

- ❍ Arthritis
- ❍ Cancer
- ❍ Diabetes
- ❍ Heart Attack/Failure
- ❍ Heart Trouble
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Stroke

YOUR FATHER:

- ❍ Arthritis
- ❍ Cancer
- ❍ Diabetes
- ❍ Heart Attack/Failure
- ❍ Heart Trouble
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Stroke

YOUR MATERNAL GRANDPARENTS:

- ❍ Arthritis
- ❍ Cancer
- ❍ Diabetes
- ❍ Heart Attack/Failure
- ❍ Heart Trouble
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Stroke

YOUR PATERNAL GRANDPARENTS:

- ❍ Arthritis
- ❍ Cancer
- ❍ Diabetes
- ❍ Heart Attack/Failure
- ❍ Heart Trouble
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Stroke

YOUR SIBLINGS:

- ❍ Arthritis
- ❍ Cancer
- ❍ Diabetes
- ❍ Heart Attack/Failure
- ❍ Heart Trouble
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Stroke

YOUR CHILDREN:

- ❍ Arthritis
- ❍ Cancer
- ❍ Diabetes
- ❍ Heart Attack/Failure
- ❍ Heart Trouble
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Stroke