PATIENT INFORMATION

CONVERGENT DENTISTRY

Welcome to Convergent Dentistry. We appreciate the confidence you place with us to provide you with our dental services. We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS NEED TO COMPLETE OUR "PATIENT INFORMATION" FORM BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**

Patient Last Name: _____ First: _____ Initial: _____

Date of Birth: _____ Sex: M F Age: _____ SS#: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed Full Time Student? ☐ Yes ☐ No School: _____

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

Home Phone: _____ Cell: _____ Bus. Phone: _____

E-mail: _____ Employer: _____

Spouse's Name: _____ Spouse's Phone: _____

Emergency Contact: _____ Emergency Phone: _____

Primary Dental Insurance: _____ Group #_____ Member #_____

Subscriber's Name: _____ Date of Birth: _____ SS#: _____

Secondary Dental Insurance: _____ Group #_____ Member #_____

Subscriber's Name: _____ Date of Birth: _____ SS#: _____

Name of Previous Dentist: _____ Date of Last Visit to Dentist: _____

How did you find us: _____ Medical Doctor:/Phone _____

INSURANCE

As a courtesy to our patients we can accept assignment of benefits payments from most insurance companies as an **out-of-network provider**, this may reduce your immediate out-of pocket expenditures. The patient portion of particular dental services is estimated and due at the time of service. This amount may be subject to adjustment when the dental services claims are adjudicated by the insurance company. In addition , certain insurance companies have annual limitations for the amount of dental services that can be reimbursed within each plan year. The patient is responsible for the full amount of dental services and the patient may not rely upon any information provided by Convergent Dentistry regarding insurance benefit coverage and payments.

MEDICARE

Section 1802 of the Social Security Act of 1997 and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, permits certain practitioners to out of Medicare and enter into private contracts with Medicare beneficiaries if specific requirements for doing so are met. Convergent Dentistry is not a Medicare provider; prescriptions written by Dr. Christopher C. Rooney, DDS, may still be covered by Medicare. Dental services may not be submitted to Medicare by Convergent Dentistry or by the patient for 2 years and a "Medicare Opt Out Affidavit" must be signed by the patient every two years.

☐ **Yes I participate in Medicare** ☐ **No I do not participate in Medicare**

PHOTOGRAPHY RELEASE

I hereby authorize Dr. Christopher C. Rooney to take photographs and or videos of my face, jaws, mouth and teeth. I understand that these will be used as a record of my care, and may be used for educational purposes, demonstrations, marketing, case presentations to new patients or in professional publications. I further understand that my name or other identifying information will be kept confidential.

I grant Dr. Christopher C. Rooney permission to use these images or videos on social media, web sites , printed or media advertising to promote Dr Rooney and Convergent Dentistry.

☐ **Yes** ☐ **No**

I grant Dr. Christopher C. Rooney permission to use these images or videos on social media, web sites , printed or media advertising to promote Dr. Rooney and Convergent Dentistry, **using my full name.**

☐ **Yes** ☐ **No**

MEDICATION LIST

CONVERGENT DENTISTRY

Medication: _____

Supplements/OTC: _____

Additional Information, Surgeries or Concerns: _____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize the release of any information concerning my health care, advice and treatment to another healthcare professional with written authorization. I hereby authorize payment of insurance benefits directly to Convergent Dentistry otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.

I understand I am financially responsible for payments in full of all accounts. By signing this statement, I agree to be responsible for payments of services not paid, in whole or in part by my insurance carrier. I attest to the accuracy of the information on this page.

Signature **X**_____ Date _____

PATIENT INFORMATION

CONVERGENT DENTISTRY

DENTAL HEALTH HISTORY

Please Check if you have/had:	Yes	No
Bad breath	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on only one side of your mouth	☐	☐
Cigarette, pipe or cigar smoking	☐	☐
Smokeless tobacco	☐	☐
Dry mouth	☐	☐
Food collecting between teeth	☐	☐
Clench or grind teeth	☐	☐
Growths or sore spots in your mouth	☐	☐
Gums—swollen, tender or bleeding	☐	☐
Head, neck, jaw pain, or aches	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐
Nitrous Oxide	☐	☐
Orthodontic previous treatment	☐	☐
Periodontal previous treatment	☐	☐
Sensitivity when your teeth come in contact with:		
Hot foods or liquids	☐	☐
Cold foods or liquids	☐	☐
Sours	☐	☐
Sweets	☐	☐
Pressure	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?	Yes	No
Local anesthetics (“Novocaine”)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofens	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other	☐	☐

	Yes	No
How often do you brush? _____		
How often do you floss? _____		
Do you have a temporomandibular (TMJ jaw) disorder?	☐	☐
Does you jaw make noise so that it bothers you or others?	☐	☐
Does your jaw ever feel tired?	☐	☐
Does you jaw get stuck so that you can not open it freely?	☐	☐
Does it hurt when you chew or open wide take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you have pain in the face, cheeks, jaw, joints throat or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw trauma?	☐	☐
Are you a habitual gum chewer?	☐	☐
Do you take medications (see medication & OTC listing on pg. 2)	☐	☐
Do you take fluoride supplements?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐
Do you drink alcohol? If so, how much per week _____	☐	☐

PATIENT INFORMATION

CONVERGENT DENTISTRY

MEDICAL HEALTH HISTORY

Please check if you have/had:	Yes	No
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Required Hospitalization	☐	☐
Have you used steroids	☐	☐
Date of last episode _____		
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Abnormal bleeding with surgery	☐	☐
Blood disease (anemia) or clotting disorders	☐	☐
Blood pressure High or Low	☐	☐
Easy bruising	☐	☐
Ever require a blood transfusion	☐	☐
Frequent nosebleeds	☐	☐
Recast Transfusions	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Emphysema	☐	☐
Epilepsy or seizures	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Head injury history	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type _____	☐	☐
HIV– positive/AIDS	☐	☐
Herpes or other STD	☐	☐
Immune deficiency	☐	☐
Kidney disease	☐	☐
Mitral valve prolapsed	☐	☐
Osteoporosis	☐	☐
Ostopenia	☐	☐
Pacemaker	☐	☐

	Yes	No
Radiation treatments	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus problems	☐	☐
Sickle cell anemia	☐	☐
Skin rash	☐	☐
Slow healing wounds	☐	☐
Stroke(s)	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐
Weight gain or loss, unexplained	☐	☐
Do you have any disease, condition, or problem not listed previously that you feel we should know about? If so, please describe: _____ _____	☐	☐

During the past 12 months, have you taken any of the following?	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drugs/supplements	☐	☐

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant? If so, expected delivery date: _____	☐	☐
Are you nursing?	☐	☐
Have you reached menopause? If so, do you have any symptoms? _____ _____	☐	☐

Patient/Parent Signature: X _____

Date: _____ Dentist Initials: _____

ORAL SCREENING CONSENT

CONVERGENT
DENTISTRY

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Oral cancer risk by patient profile is as follows:

Increased risk:	*patients ages 18-39*
High risk:	*patients age 40 and older,' tobacco users (any age, any type within 10 years)*
Highest risk:	*patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer*

We have recently incorporated ViziLite" Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is $40.00.

Yes, I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No, I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____

WRITTEN FINANCIAL POLICY

CONVERGENT DENTISTRY

Convergent Dentistry

11111 Nall Ave, Suite 100 | Leawood, KS, 66211-1624 | (913) 491-9119

Thank you for choosing Convergent Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from: Cash, Check, Visa, MasterCard, American Express, Discover Card or Care Credit[1]

We offer a 3% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to the start of care for treatment plans of $5000.00 or more.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card

- Allow you to pay over time (six or twelve months, depending on amount financed)
- No annual fees or pre-payment penalties

Please note: Convergent Dentistry requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

Payment is due in full at time of service. For plans requiring multiple appointments, alternative payment arrangements may be provided. For treatment plans of $1000 or more, a deposit of half the total cost is required to secure your initial treatment appointment.

We charge a 10% service charge on all past due accounts past ninety (90) days. Any account that has not received payment in 120 days will be turned over to a collection agency that will pursue the patient/responsible party for reimbursement. The patient/responsible party will be responsible for any costs associated with these collection efforts. This will negatively impact your credit history and limit the treatment you can receive at our office.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and provide you with the documentation you need to receive reimbursement for your treatment. Your dental insurance is a contract between you and your insurance company. Payment will be due for any remaining balance that insurance has not paid on your behalf.

A reservation fee of $50 is required for patients who miss or cancel more than two (2) times in a twelve (12) month consecutive period without prior notification of the cancellation of at least two (2) business days.

Convergent Dentistry charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval