

Patient Registration Form

Email:				Today's Date:			
Preferred Name: ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.				Referred by:			
Name:		Home Phone: <i>include area code</i>		Cell Phone: <i>include area code</i>			
Last		First		Middle		()	
Address:				City:		State: Zip:	
Mailing address							
SS#:				Date of Birth:		Sex: M F	
Employer:				Business Phone: <i>include area code</i>			
				()			
Emergency Contact:		Relationship:		Home Phone: <i>include area code</i>		Cell Phone: <i>include area code</i>	
				()		()	
College Student Status: ☐ Full Time ☐ Part Time				Please provide school info: School Name:_____			
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired				Address:_____			
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				Address 2:_____			
Pref. Pharmacy: Phone: ()				City, State, Zip:_____			

Dental Insurance Information

Primary Insurance Information	
Name of Insured: _____	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	
Secondary Insurance Information	
Name of Insured: _____	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes No DK		Yes No DK
Do your gums bleed when you brush or floss?	☐ ☐ ☐	Do you have earaches or neck pains?	☐ ☐ ☐
Are your teeth sensitive to cold, hot, sweets or pressure? .	☐ ☐ ☐	Do you have any clicking, popping or discomfort in the jaw?	☐ ☐ ☐
Is your mouth dry?	☐ ☐ ☐	Do you brux or grind your teeth?	☐ ☐ ☐
Have you had any periodontal (gum) treatments?	☐ ☐ ☐	Do you have sores or ulcers in your mouth?	☐ ☐ ☐
Have you ever had orthodontic (braces) treatments?	☐ ☐ ☐	Do you wear dentures or partials?	☐ ☐ ☐
Have you had any problems associated with previous dental treatment?	☐ ☐ ☐	Do you participate in active recreational activities?	☐ ☐ ☐
Is your home water supply fluoridated?	☐ ☐ ☐	Have you ever had a serious injury to your head or mouth?	☐ ☐ ☐
Do you drink bottled or filtered water?	☐ ☐ ☐	Date of your last dental exam:	
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY		What was done at that time?	
Are you currently experiencing dental pain or discomfort? ☐ ☐ ☐		Date of last dental x-rays:	
What is the reason for your dental visit today?			
How do you feel about your smile?			

Patient Name:

Birth Date:

Date Created:

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	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes	
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes	
Are you on a special diet?	☐ Yes ☐ No		
Do you use tobacco?	☐ Yes ☐ No		
Do you use controlled substances?	☐ Yes ☐ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant?	☐ Nursing?	☐ Taking oral contraceptives?
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Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
Other?	☐	If yes	

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 Problems	☐ 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						
Have you ever had any serious illness not listed above?		☐ Yes ☐ No	If yes				

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:

X

Date: _____

Office Policies

Summit Lakes Dental Care provides comprehensive dental treatment to our patients in a friendly, professional, and caring environment. Our goal is to make you feel relaxed and comfortable during your dental visit. We can help you with your cosmetic and restorative dental needs. We strive to provide you and your family with the most pleasant dental visit ever!

Appointments

Your time is very important to us. We will do everything in our power to have you in-and-out on time. Likewise, we ask that you respect our time, and the time of other patients. If you are scheduled for an appointment and need to reschedule, we require 48 hours' notice. Late cancellations and missed appointments do not allow sufficient time for us to offer your appointment time to another patient. Short notice cancellations may be charged a broken appointment fee.

Our Payment Policy

Payment of deductible & co-insurance, which is the estimated amount not covered by your insurance company, is required at the time we provide service to you. *Please remember, the patient is fully responsible for all fees charged by this practice (regardless of insurance coverage). Any balance remaining after the patient's insurance has paid is the patient's responsibility. To avoid any further finance charges, payments need to be made within 30 days of the original dental treatment date.* We will be happy to discuss any financial aspects of your treatment before it is initiated. As a courtesy to our patients, we will also contact your insurance company in advance to get a breakdown of your current dental coverage from the updated/current dental insurance you have provided to us.

We accept the following methods of payment: Visa, MasterCard, Discover, cash, check.

Please indicate if we may send you appointment reminders via e-mail. ☐ yes ☐ no

Signed: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Summit Lake Dental Care
3741 S.W. Raintree Drive
Lee's Summit, MO 64082

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of **Summit Lake Dental Care's** *HIPAA Notice of Privacy Practices*.

I understand that **Summit Lake Dental Care's** *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Summit Lake Dental Care's** revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about **Summit Lake Dental Care's** *HIPAA Notice of Privacy Practices*, I may contact Dr. David Beck at 816.875.3339.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Summit Lake Dental Care** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Summit Lake Dental Care's** privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Dr. Suzanne Beck, noted above, for assistance.

Patient Signature

Date

Signature of Personal Representative

Print Name of Personal Representative

Relationship of Personal Representative to
Patient

FOR OFFICE USE ONLY

Summit Lake Dental Care made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, **Summit Lake Dental Care** was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe): _____

Date Received

By

Patient ID

Summit Lakes Dental Care
Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care.

We may disclose your health information to your family or friends, or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a “Part 2 Program”) through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:

Privacy Official Name: Dr. David Beck_____

Telephone: 816-875-3339_____ **Fax:** 816-623-5392_____

Address: 3741 SW Raintree Dr. Lee's Summit, MO 64082_____

Email: info@summitlakesdental.com_____