OLATHE
FAMILY DENTISTS
KARL BREUCKMANN, DDS
www.OlatheFamilyDentists.com
913-782-6533

Patient Information

Name_____

Preferred Name _____ Date of Birth_____

Address_____City_____ST_____Zip_____

Cell Phone(_____)_____-_____ Home Phone(_____)_____-_____

S.S.N._____ Email Address_____

Employer _____ Work Phone(_____)_____-_____

Work Address_____

Referred By_____

Responsible Party (If someone other than the Patient)

Name_____Home Phone(_____)_____

Cell Phone(_____)_____-_____Email_____

Address_____City_____ST_____Zip_____

Employer _____ Work Phone(_____)_____-_____

Dental Insurance Information

Name of Insured_____Date of Birth_____

Employer_____

Insurance Company_____ Phone(_____)_____-_____

S.S.#/I.D.#_____Group #_____

Emergency Contact

Name_____ Relationship _____

Phone (_____)_____ Alt Phone (_____)_____

Authorization and Release

I certify the above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and records of any treatment rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners. I authorize my insurance company to pay directly to the dentist from which services were provided. I understand my dental insurance may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature_____Date_____

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I, _____, hereby give **Karl A. Breuckmann DDS, PA** the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

Signature_____ Date_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my or my dependents dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1½% late charge (18%APR) may be added to my account. If required, I also understand a check of my credit history may be made.
5. I understand that a 10% deposit will be required on all major treatment to reserve an appointment with the Doctor.
6. I understand that 48 hours' notice is required for schedule changes and that a fee/or loss of deposit may apply should notice not be received.

Patient's
Signature_____Date_____

Parents/Responsible Party's Signature_____

Relationship to the Patient_____Date_____

Witness_____Date_____

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Acknowledgement of Receipt of Notice Of Privacy Practices

I have seen and/or received a copy of this office's Notice of Privacy Practices.

_____
Please Sign Your Name

_____
Date

You May Refuse to Sign This Acknowledgement

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.
- Communication barriers prohibited obtaining the acknowledgment.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please Specify)_____