WSU-AEGD DENTAL CLINIC

REGISTRATION FORM

Today's Date:	**How did you hear about our clinic?**

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status: (please circle) Single○ Married○ Divorced○ Widowed○

Address:	City, State, and Zip code:	Birth date:	Age:	Sex: ○ M ○ F

Is patient responsible party? ○ Yes ○ No

Social Security no.:	Home phone no.:	Work phone no.:	Cell phone no.: ☐ Check if you would like to receive text reminders
Employer:	Employer address:		Employer phone no.:

Email: _____ ○ I would like to receive email correspondences

Person responsible for bill (Relationship to patient):	Birth date:	Address (if different):	Home/Cell phone no.:
Employment Status: ○ Full Time ○ Part Time ○ Retired	Employer:	Employer address:	Employer phone no.:

INSURANCE INFORMATION

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:

Relationship to Patient:

Please notify us if you have secondary insurance:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home/Cell phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize WSU-AEGD Dental Clinic or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

WICHITA STATE UNIVERSITY

WICHITA STATE UNIVERSITY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Wichita State University is legally required to provide you with a copy of its **NOTICE OF PRIVACY PRACTICES** the first time you receive care at WSU. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

☐ I have received a copy of the Notice of Privacy Practices

☐ I have previously received a copy of the Notice of Privacy Practices

☐ I do not want a copy of the Notice of Privacy Practices

Signature of Patient/Legal Representative	Date
Printed Name of Patient/Legal Representative	Phone Number
Printed Name of Patient (if different from above)	myWSU ID (if applicable)

Wichita State University

Eaglesoft Medical History

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.

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

Women: Are you…

☐ Pregnant/ trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

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	O Yes O No	Excessive Bleeding	O Yes O No	Mitral Valve Prolapse	O Yes O No
Alzheimer's Disease	O Yes O No	Excessive Thirst	O Yes O No	Osteoporosis	O Yes O No
Anaphylaxis	O Yes O No	Fainting/Dizziness	O Yes O No	Pain in Jaw Joints	O Yes O No
Anemia	O Yes O No	Frequent Cough	O Yes O No	Parathyroid Disease	O Yes O No
Angina	O Yes O No	Frequent Headaches	O Yes O No	Psychiatric Care	O Yes O No
Arthritis/ Gout	O Yes O No	Glaucoma	O Yes O No	Radiation Treatments	O Yes O No
Artificial Heart Valve	O Yes O No	Hay Fever	O Yes O No	Recent Weight loss	O Yes O No
Artificial Joint	O Yes O No	Heart Attack/ Failure	O Yes O No	Renal Dialysis	O Yes O No
Asthma	O Yes O No	Heart Murmur	O Yes O No	Rheumatic Fever	O Yes O No
Blood Disease	O Yes O No	Heart Pacemaker	O Yes O No	Rheumatism	O Yes O No
Blood Transfusion	O Yes O No	Heart Trouble/ Disease	O Yes O No	Scarlet Fever	O Yes O No
Breathing Problems	O Yes O No	Hemophilia	O Yes O No	Shingles	O Yes O No
Bruise Easily	O Yes O No	Hepatitis A	O Yes O No	Sickle Cell Disease	O Yes O No

Wichita State University

Eaglesoft Medical History

Patient Name: Birth date: Date created:

Cancer	O Yes O No	Hepatitis B or C	O Yes O No	Sinus Trouble	O Yes O No
Chemotherapy	O Yes O No	Herpes	O Yes O No	Sleep Apnea	O Yes O No
Chest Pains	O Yes O No	High Blood Pressure	O Yes O No	Spina Bifida	O Yes O No
Cold Sores\Fever Blisters	O Yes O No	High Cholesterol	O Yes O No	Intestinal Disease	O Yes O No
Congenital Heart Disorder	O Yes O No	Hives or Rash	O Yes O No	Stroke	O Yes O No
Convulsions	O Yes O No	Hypoglycemia	O Yes O No	Swelling of Limbs	O Yes O No
Cortisone Medicine	O Yes O No	Irregular Heartbeat	O Yes O No	Thyroid Disease	O Yes O No
Diabetes	O Yes O No	Kidney Problems	O Yes O No	Tonsilitis	O Yes O No
Drug Addiction	O Yes O No	Leukemia	O Yes O No	Tuberculosis	O Yes O No
Easily Winded	O Yes O No	Liver Disease	O Yes O No	Tumors or Growths	O Yes O No
Emphysema	O Yes O No	Low Blood Pressure	O Yes O No	Ulcers	O Yes O No
Epilepsy or Seizures	O Yes O No	Lung Disease	O Yes O No	Yellow Jaundice	O Yes O No

Have you ever had any serious illness not listed above? OYes ONo 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:**

Wichita State University

Eaglesoft Dental History

Patient Name: Birth date: Date created:

Date of last dental visit: _____ Last dental cleaning:_____ Last full-mouth X-rays date:_____

What was done during your last dental visit? _____

How often do you have dental examinations? _____

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

What dental aids do you use (i.e. Waterpik, toothpicks, etc.)?_____

Do you have any dental problems right now? O Yes O No *If yes, please describe:*_____

Are any of your teeth sensitive to…		**Have you experienced…**	
Hot and Cold?	O Yes O No	Clicking or popping of the jaw?	O Yes O No
Sweets?	O Yes O No	Pain (joint, ear, side of face)?	O Yes O No
Biting and chewing?	O Yes O No	Difficulty in opening or closing the mouth?	O Yes O No
Have you noticed any mouth odors or bad taste?	O Yes O No	Difficulty in chewing on either side of the mouth?	O Yes O No
Do you frequently get cold sores, blisters, or any other oral lesions?	O Yes O No	Headaches, neck aches or shoulder aches?	O Yes O No
Do your gums bleed or hurt?	O Yes O No	Sore muscles (neck, shoulders)?	O Yes O No
Have you noticed any loose teeth or change in your bite?	O Yes O No	Are you satisfied with your teeth's appearance?	O Yes O No
Does food tend to become caught in between your teeth?	O Yes O No	Would you like to save all your teeth?	O Yes O No
		Do you feel nervous about having dental treatment?	O Yes O No
		Have you ever had an upsetting dental experience?	O Yes O No

Do you…		**Have you ever had…**	
Clench or grind your teeth while awake or asleep?	O Yes O No	Orthodontic treatment?	O Yes O No
Bite your lips or cheeks regularly?	O Yes O No	Oral surgery?	O Yes O No
Mouth breathe while awake or asleep?	O Yes O No	Periodontal treatment?	O Yes O No
Snore or have any other sleeping disorders?	O Yes O No	A mouthguard	O Yes O No
		A serious injury to the mouth or head?	O Yes O No

Have you ever been told to take premedication prior to dental treatment? O Yes O No

Is there anything else about having dental treatment that you would like us to know? O Yes O No

If yes, please describe: _____

WICHITA STATE UNIVERSITY

Advanced Education in General Dentistry Program (AEGD)
Program and Patient Information

Wichita State University's Advanced Education in General Dentistry is a one-year postdoctoral education program within the College of Health Professions. The purpose of the program is to provide recently graduated dental students an opportunity for advanced comprehensive clinical experience. Patients are an essential part of this teaching program. **However, not all patients presenting for treatment can be accepted.** Many of the treatment requirements will be beyond the level of management of the AEGD resident clinician. If this is the case, you will be advised as to the proper procedure for transferring the diagnostic aids to the dentist of your choice.

In application for dental treatment, I understand and agree to the below statements and criteria:

1. **A Faculty Screening and/or Comprehensive Exam will be performed** to determine if general health, oral health, dental needs and time availability meet the requirements for patient acceptance to the program. For this initial examination, a fee will be charged. _____(Please initial)

2. To complete an adequate diagnosis for your existing dental condition, **additional aids may be required**, including, but not limited to, various radiographs (x-rays), diagnostic casts, photographs, laboratory tests and consultation services. If needed, there will be charges for these services. One or two additional visits may be required to complete the diagnosis. _____(Please initial)

3. If you are found to be eligible for our program, you will then be assigned a resident. **NOTE: Treatment within this clinic proceeds more slowly than a private office**, as services are provided by AEGD residents and are carefully monitored by faculty members. Complete cooperation and understanding among the patient, resident and faculty member is essential for successful treatment. Although it is the goal of the AEGD program to complete all of your needed treatment, the completion of all needed procedures is not a guarantee. All patients under the age of 18, except emancipated minors, must have written consent from their parents of legal guardians before acceptance of treatment. _____(Please initial).

4. Patients who utilize the AEGD program and clinic for continuing care **will require a periodic diagnostic review** and possible need for new radiographs (x-rays). A periodic review and x-rays will require a fee.

5. **Residents rotate on a yearly basis**, so continuing care patients will need to meet the new residents during a short, transition appointment. There will be no charge for this appointment.

6. **It is important that patients arrive on time for all appointments.** At the discretion of the instructor and resident, **an appointment may be rescheduled if patient is more than 15 minutes late**. _____(please initial)

7. **We require a 24 hour notice for cancellation of appointments**. After three (3) missed/broken appointments, your case will be reviewed by the AEGD Clinic Director for dismissal from our program._____(Please initial)

8. **The WSU Dental Clinic follows the University Schedule** and is closed on all national holidays, including winter break during the Christmas holiday and also during inclement weather. If the public is notified campus is closed, the clinic will also be closed. _____(Please initial)

Patient Signature: _____ **Date:** _____

Print Name: _____

Parent or Legal Guardian: _____

WICHITA STATE UNIVERSITY

Advanced Education in General Dentistry Program (AEGD)

Patient Financial Information and Consent

As a patient serving clinic within an educational program, fees for dental services have been set and all payment is due at the time of services rendered.

We do **not** offer sliding scale fees or adjusted fees based on income. We are **not** a Medicaid or KanCare provider.

Please read, initial after each statement and sign at the bottom of the page:

1. Payment is due at time of services- Payment is due at the time of appointment. If a patient has insurance, the co-pay or out-of-pocket expense is due at time of service. ____

2. If a patient has dental Insurance- We are an in-network provider for the following insurance companies: Delta Dental, Blue Cross Blue Shield, Aetna, MetLife and Cigna. While we accept all private dental insurances, for those patients with out-of-network policies, payment is due in full at time of service. We will then file your claim and have your insurance company reimburse you. ____

3. Estimate of Payment- We provide a close estimate of patient out-of-pocket expenses. For any major dental service, we highly recommend a pre-determination be submitted to your insurance company. _____

4. Delinquent Accounts- If a patient elects not to pay a debt in full, or within 90 days, the account will be turned over to collection agency, which will report your name to the credit bureau and supplementary communications may use pre-recorded voice or texting to cellular or or wireless devices. Collection fees may be charged to your account, up to 33%. **Please note: as an institution of the State of Kansas, your name may be submitted tothe Kansas Setoff Program, resulting in any debt owed to be collected from state income tax returns/refunds. ____**

5. Appointment Cancellations/Failure to Show- We require a 24 hour notice for cancellations or rescheduled appointments. Failure to show for an appointment or cancel with 24 hours may be subject to a $50 Cancellation Fee that must be paid before rescheduling. If calling after hours to cancel, please leave a voice message so it can be retrieved the following day.

Patient Signature: _____Date:_____
Print Name: _____
Parent or Legal Guardian: _____

WICHITA STATE UNIVERSITY

PATIENT PHOTO/VIDEO/AUDIO AUTHORIZATION AND RELEASE FORM

NOTE: This form is NOT required for photos or videos of patients used for the purposes of treatment or diagnosis, where the photo and/or video becomes part of the patient's medical record and is not used for any other purpose. The Wichita State University General Dentistry Clinic (AEGD) is a training facility for students enrolled at WSU. It is standard procedure for appointments and treatment to be videotaped or observed by others for supervision and educational purposes. In addition, students and faculty present clinical cases during their academic classes. You understand that, regardless of whether you sign this Authorization, your health information and Media may be shared internally at WSU in classrooms and other teaching and consultative environments.

SECTION A. INDIVIDUAL INFORMATION		
INDIVIDUAL'S NAME (LAST, FIRST, MIDDLE INITIAL):	DATE OF BIRTH (MM/DD/YYYY):	
STREET ADDRESS (INCLUDING CITY, STATE, AND ZIP):		
PHONE NUMBER:		

SECTION B. PHOTOGRAPHY/VIDEOGRAPHY/AUDIOGRAPHY RELEASE

I authorize the WSU General Dentistry to take photographs and/or videos and/or audio recordings, or to allow third parties to take photographs and/or videos and/or audio recordings (collectively, "Media") of me for the following uses (check all that apply). You understand that by checking boxes below, the Media you have authorized for disclosure may be seen by members of the general public.

For Educational or Training Purposes Within WSU	
☐ In presentations by WSU faculty, staff, employees, and students to entities or individuals ***within*** WSU, for educational or training purposes	☐ In small group or one-on-one meetings with WSU faculty, staff, employees, or students for educational or training purposes
For Public Relations Purposes Outside of WSU	**For Medical or Educational Purposes Outside of WSU**
☐ On WSU internet and intranet sites	☐ In professional journals and other publications, including textbooks and electronic publications
☐ In WSU publications and brochures	☐ In presentations by WSU faculty, staff, employees, and students to entities or individuals ***outside of*** WSU, including at professional and educational conferences or seminars
☐ In the public media, such as newspapers, magazines, on the internet and on television	
☐ In presentations, publications, brochures, advertisements, or articles by non-WSU agencies or companies, such as other non-profit organizations or for-profit companies who provide support to WSU	

SECTION C. USE OF NAME

_____ initial **I consent to the use of my name**. I understand that I may be identified by name in printed, internet, or broadcast information that might accompany the media of me.

-OR-

_____ initial **I do not consent to the use of my name**. I understand that, even though my name will not be used, it is possible that someone may recognize me based on the media alone.

SECTION D. SIGNATURE/DATE

By signing below, I understand that:

- I do not have to sign this Authorization
- My refusal to sign this Authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- Information shared under this Authorization may be subject to redisclosure, and such redisclosures may be made to anyone, including but not limited to media outlets and the general public, and may no longer be protected by federal or state law.

- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, I must provide a written revocation to the WSU clinic for whom I signed this Authorization.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this Authorization.
- Any facsimile or copy of this Authorization authorizes the release of the records requested herein.
- I acknowledge that I have received a copy of this Authorization.
- Unless otherwise revoked, this authorization will expire ten (10) years from the date it is signed.

Signature of Individual (if 18 years of age or older): _____ Date _____

Signature of Parent or Legal Representative (if applicable): _____ Date _____

Relationship to Individual, if not signed by Individual: _____