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: _____

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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. Recurring Monthly Payments- For established patients, we do offer automatic monthly payments. These are set up through the University online payment system through credit card or ACH. Monthly payments must be set and approved by the Clinic Director. _____

5. Delinquent Accounts- If a patient elects not to pay a debt in full or set up a payment plan, 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 to the Kansas Setoff Program, resulting in any debt owed to be collected from state income tax returns/refunds. _____

Patient Signature: _____Date:_____

Print Name: _____

Parent or Legal Guardian: _____

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

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.

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?

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:_____