MEYER
FAMILY DENTISTRY

Welcome to Our Office

Please complete the following information so that we may better serve you.

Date:_____

PATIENT INFORMATION

Title: Mr. Mrs. Ms. Miss Dr. Legal Name:_____ □ Male □ Female

Preferred Name:_____ Birthdate:_____ Marital Status:_____

Address:_____ City:_____ St:_____ Zip:_____

Home #:_____ Work #:_____ Cell #:_____

E-Mail:_____ SSN: _____-_____-_____

Employer:_____ Occupation:_____

If Patient is a Minor, Give Responsible Party's Name:_____

Relationship to Patient:_____

How did you hear about our Practice? _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance	Secondary Dental Insurance (if applicable)
Subscriber Name:_____ Relationship to Subscriber: □ Self □ Spouse□ Child □ Other Subscriber ID/SSN:_____ Subscriber DOB:_____ Subscriber's Employer:_____ Insurance Company:_____ Group #:_____	Subscriber Name:_____ Relationship to Subscriber: □ Self □ Spouse□ Child □ Other Subscriber ID/SSN:_____ Subscriber DOB:_____ Subscriber's Employer:_____ Insurance Company:_____ Group #:_____

EMERGENCY NOTIFICATION INFORMATION

Primary Care Physician:_____ Phone:_____

In case of an emergency, who should be notified?

Name:_____ Phone:_____ Relationship:_____

Health History

Printed Name:_____

Oral Care Habits: Toothbrush: Regular or Electric Floss: Regular/Hydrofloss/Waterpik/None Mouth Rinse:

Please answer these Questions about your Dental Health (please check if YES)	
□ Gums bleed when brushing/flossing	□ Frequent Headaches
□ Teeth Sensitive to Hot or Cold	□ Clench or Grind Teeth
□ Pain in teeth? Where?	□ Orthodontic Braces now or in Past
□ Clicking, Pain, Discomfort or Difficulty opening Jaw	□ Dental visits make you anxious

Please Describe the reason for your visit:_____

_____

_____

Is there anything you'd like to change about your smile? Please explain:

_____

_____

Have you been in the hospital in the past 2 years? □ YES □ NO Explain:_____

Current or Former Smoker? □ YES □ NO Packs/day_____ For how long?_____ Quit Date:_____

Current or Family History of Diabetes? □ YES □ NO Self/Mother/Father Type I or Type II Current A1C:_____

Current or Previous treatment for Osteoporosis/Bone Cancer? □ YES □ NO
Oral/IV treatment with: □ Boniva □ Fosamax □ Zometa
If YES, which medication and Why?_____

Do you have any prosthetic device (e.g. heart valve or stent, artificial joint, implant, pacemaker, etc) □ YES □ NO
Do you require a Pre-Medication of antibiotics before dental procedures as ordered by a physician? □ YES □ NO
If YES, which antibiotic do you currently take?_____
FEMALES: Are you pregnant? □ YES □ NO
Are you allergic or sensitive to any medicine, dental anesthetic or latex products? □ YES □ NO
If YES, to what?_____

Prescription Medications or over-the-counter medications: (attach separate sheet if needed)

Medication and Dosage	Why taking:
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Do you now or have you ever had any of the following diseases or medical conditions?

□ Increased Urination	□ Difficulty Laying Back in Chair	□ Pacemaker
□ Increased Thirst	□ Drug Addiction/Alcoholism	□ Organ Transplant
□ Allergies	□ Emphysema	□ Palpitations/Arrhythmia
□ Aneurysm	□ Eye/Vision Disorders	□ Panic Attacks/Phobias
□ Arthritis	□ Fainting/Dizziness	□ Persistent Cough
□ Asthma	□ Hearing Loss/Ear Problems	□ Psychiatric Treatment/Depression
□ Bisphosphonates/Osteoporosis	□Heart Disease/Heart Attack/MI	□ Recent Weight Gain or Loss
□ Blood Transfusion	□ Heart Murmur	□ Rheumatic Fever
□ Cancer/Malignancies	□ Heart Surgery/Angioplasty/Stent	□ Seizures/Epilepsy/Convulsions
□ Chemo/radiation therapy	□ Hemophilia/Prolonged Bleeding	□ Severe Headaches/Dizziness
□ Chest Pain/Angina Pectoris	□ Hepatitis A, B or C/Liver Disease	□ Sexually Transmitted Disease
□ Colitis/Crohn's/Intestinal Problems	□ High Blood Pressure	□ Shortness of Breath
□ Chronic Bronchitis	□ High Cholesterol	□ Sinus Problems
□ Chronic Tiredness/Fatigue	□ High Fear of Dentistry	□ Stroke/TIA
□ Congenital Heart Defect	□ HIV+/AIDS	□ Thyroid Problems
□ Coronary Artery Disease/Bypass	□ Kidney, Bladder Problems/Dialysis	□ Tuberculosis (TB)
□ Diabetes/High Blood Sugar	□ Mitral Valve Prolapse	□Weakness/Tingling/Numbness

Any additional information (disease, condition or problem not listed) we should know? □ YES □ NO

If Yes, Explain_____

To the best of my knowledge, the information I have given is true and correct. I understand that this will be held in confidence and it is my responsibility to inform Meyer Family Dentistry of any future changes in my medical status.

Signature of Patient, Parent or Guardian:_____Date:_____

Relationship to Patient: □ Self □ Parent □ Guardian □ Other:_____

Meyer Family Dentistry

Rodney A. Meyer, DDS, LLC

Financial Policy

The primary goal of our office is to provide you with the quality dental care you need. We will strive to make this as affordable as possible.

Please understand that your dental insurance was not created to pay for all your dental care needs. Unlike health insurance, dental insurance was created to assist with the costs of some preventative treatment needs; x-rays, simple cleanings, simple fillings, etc… We will assist you with your benefit eligibility before treatment to help calculate patient responsibility. This payment is due at the time of service.

We accept payment in the form of Cash, Check and Credit Card

Insurance

Meyer Family Dentistry provides insurance company billing as a courtesy to our patients. The patient portion of dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely solely upon any information provided by Meyer Family Dentistry staff regarding his/her remaining benefit in any such benefit period. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You as a patient are always responsible for any charges that are not covered by your insurance.

Delinquent Payments

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed hygiene and doctor exam appointments at the rate of $50.00 per appointment at the discretion of Meyer Family Dentistry. Please help us service you better by keeping scheduled appointments.

I have read and agree to the Financial Policy and the Cancellation Policy of Meyer Family Dentistry.

Signature of Patient or Responsible Party:_____

Date:_____

Meyer Family Dentistry

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES 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 of unsecured protected health information. We must follow the privacy praxes that are describe 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 suing 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 record, and mental health records may be entitled to special confidentiality protection 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 determination 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, conduction 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 the participate in your care or int eh 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 healthcare decisions of 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 wit products or devices;
- Notify a person of 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 authorize 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 US 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 heath care system, government programs, and compliance with civil right 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 Mae, either by requesting party or us, to tell you about the request or to obtain an order protection 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 you 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 activists, 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 of purposes of treatment, payment or healthcare operations, we may use and disclose your Part 2 Program record for treatment, payment and healthcare 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 s a letter to the address at eat end of his 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

Right to Request a Restriction. You have the right to request additional restrictions on our use of 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 you 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 bet 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 connect 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 and amendment, we will prod 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 Website 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 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 US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US department of Health and Human Services.

PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:

Privacy Official Name: Dr. Rodney Meyer
Telephone: 913-451-3400 Fax: 913-451-3992
Address: 11021 Hauser St, Lenexa KS 66210
Email: frontdesk1@rodneymeyerdds.com

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent
- Photos will often be taken of your case to be submitted for insurance purposes and occasionally used for marketing and education purposes.

May we phone, email or send a text to you to confirm appointments?	**Yes**	**No**
May we leave a message on your answering machine at home or on your cell phone?	**Yes**	**No**
May we discuss your medical condition with any member of your family	**Yes**	**No**

If Yes, please name the members allowed:

_____

This consent was signed by:_____

(Print Name)

Signature:_____ Date:_____

Witness: _____ Date:_____

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize
Dr. Rodney A. Meyer DDS and staff, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Marketing material, including websites and printed materials, patient education
- I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.
- I do not expect compensation, financial or otherwise, for the use of these photographs.
- ☐ Please check if you do not authorize photos to be used for any of the above purposes.

We will take a photo to be used for your file only

- Signature (Patient) _____
- Date _____