

**PO Box 297  
Hedgesville, WV 25427  
304 754-8803  
KenBarneydds.com**

**General Dentistry \* Neuromuscular Dentistry \* Cosmetic Dentistry\*Sleep Medicine**

**WELCOME TO OUR PRACTICE**

Welcome to the office of Dr. Kenneth C. Barney and his team. We are pleased you have chosen our office for your dental care. Our practice is dedicated to providing superior dental care and we are proud of our dedication to our patients. Our goal is to help you feel and look your best through excellent dental care. You will find that our approach to dental care aims for excellent dental health, comfort, and satisfied patients. Our office is equipped with state of the art equipment, computers and instrumentation.

**YOUR FIRST VISIT**

On your first visit, a permanent record will be established. You will be asked to complete a brief health history questionnaire. Necessary records will be taken, if needed, including radiographs, photographs, and study models of all teeth in order that the Doctor can best give a full and proper assessment. We will then discuss potential treatment options and fees, and answer any questions you may have.

**APPOINTMENTS**

Patients are seen by appointments. We value our patients' time and therefore strive to stay on our schedule. Please assist us by being on time for your appointments. IF we are seriously delayed, we will try to notify you. If you are unable to keep your appointment or are going to be late, please call our office as soon as possible. This courtesy allows us to be of service to other patients in need. In order to avoid a cancellation fee, 24 hours advanced notice is required to make a change in scheduled appointments during regular business days (Mon-Thurs.)

**PATIENT CONCERNS**

Please feel free to call our office if you have any questions regarding your treatment, appointments, or prescriptions. Our staff is specially trained to answer your questions. If you need to speak with Dr. Barney personally, our office staff will arrange for him to return your call as soon as conditions permit.

**UNDERSTANDING COSTS**

Excellent dental care is one of the best investments you will ever make. Dental conditions vary in complexity and severity, and fees reflect these differences. Fees for services rendered in our office are based on the Doctor's skill, knowledge, judgment, experience and expertise.

At the time of scheduling your next treatment, our office staff will discuss your financial arrangements in detail. Our office chooses to be a private fee for service practice. Payment is due when services are rendered. **Please do not ask us to bill you for your appointment.** Financial

options are available through third party financing (Care Credit is the financial institution we work with). Our office accepts Master Card, Visa, Discover, cash or personal check also.

### **INSURANCE**

Our office will process your dental insurance as a courtesy. We accept dental insurance assignments providing the insurance will send payment to our office and with the understanding that any uninsured portion that is not covered by your dental plan is to be paid by you at the time of service. Your dental insurance coverage is based on the policy or contract your employer purchased. Depending on your specific policy, your dental insurance plan may not cover fully our dental fees for services rendered. Dr. Barney does not participate with any insurance companies as he does not want to have the insurance company dictate the type of care you receive. Our office is ultimately working for you, not the insurance company. Please remember the ultimate financial responsibility is yours.

### **SPECIALIST REFERRALS**

As a general dental practice we will be in contact with the doctors and health care providers who referred you to our office to reassure the continuity of treatment. At times, the Doctor will also recommend our patients consult specialist to help assist in needed specialty care and services that are appropriate in providing the best quality care and outcome.

### **NEW PATIENT REFERRALS**

Your kind referral is the best compliment we could ever receive! We are always happy to accept new patients. We welcome your referrals of friends, co-workers, family members and relatives. We value your trust and confidence in us and will take special care of the people you refer. Thank-You!!

### **ABOUT THE STAFF**

Dr. Barney has chosen a qualified team to assist him in treating and caring for each one of his patients in a quality, individualized manner. His front office personnel are experienced, skilled, trained and qualified to meet your needs and concerns. All team members have taken extensive continuing education to enhance their skills to better serve you.

### **OUR TEAM MEMBERS:**

Sonie  
Shelly

Thank you again for giving us the opportunity to serve you. We know you will find our office to be pleasant and professional every time you visit us. We look forward to seeing you

**WELCOME**

**KENNETH C. BARNEY, D.D.S., FELLOW LVI**  
**OFFICE OF DENTAL EXCELLENCE**  
*LVI Fellow*

Date: \_\_\_\_\_

**PATIENT INFORMATION**

NAME \_\_\_\_\_ ( Married  Single  Other)  
Male ( Female ( PREFERRED Name \_\_\_\_\_

ADDRESS \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SS# \_\_\_\_\_

CONTACT NUMBERS (Check where you would prefer we call or contact you)

(  ) Home Phone \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

(  ) Work Phone \_\_\_\_\_

(  ) Cell Phone \_\_\_\_\_

PLACE OF EMPLOYMENT/SCHOOL \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**FAMILY INFORMATION**

**HUSBAND (or father)**

\_\_\_\_\_  
Last First M

\_\_\_\_\_  
Street City, State Zip

\_\_\_\_\_  
Home # Work #

\_\_\_\_\_  
Birthdate SS#

\_\_\_\_\_  
Employer

**WIFE (or mother)**

\_\_\_\_\_  
Last First M

\_\_\_\_\_  
Street City, State Zip

\_\_\_\_\_  
Home # Work #

\_\_\_\_\_  
Birthdate SS#

\_\_\_\_\_  
Employer

**IN CASE OF EMERGENCY**

**Outside of immediate family or household**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

**ACCOUNT/PAYMENT**

**Person responsible for account**

\_\_\_\_\_  
Signature

**Preferred Method of Payment**

(  ) Cash or Check

(  ) Credit Card

( ) Alternative Billing source (ask

OFFICE OF DENTAL EXCELLENCE

KENNETH C. BARNEY, D.D.S.

Dental History

Do you have a specific dental problem? Yes No
Do you have regular dental care? Last Visit Yes No
Do you think you have decay, gum disease, or jaw problems? Yes No
Do your gums ever bleed? Yes No
Do you Floss? How Often Yes No
Are you interested in improving your smile? Yes No
Would you like to have whiter teeth? Yes No
Does food catch between your teeth? Yes No
Do you ever have clicking, popping or discomfort in your jaw joint? Yes No
Do you clench or grind your teeth? Yes No
Have you ever had a bad dental experience? Yes No
Do you smoke or chew tobacco? Yes No
Name of previous dentist and location (optional)
Last date of X-rays: Bitewings Panorex Full series

SYMPTOMS Check all that apply

- ( ) Headaches ( ) Facial Pain
( ) TMJ Pain ( ) Tender sensitive teeth
( ) TMJ Noise ( ) Difficulty Chewing
( ) Limited Opening ( ) Neck Pain
( ) Ear Congestion ( ) Postural Problems
( ) Dizziness ( ) Tingling/numbness in fingers
( ) Ringing in the ears ( ) Hot and Cold sensitivity
( ) Difficulty Swallowing ( ) Nervousness
( ) Loose teeth ( ) Insomnia
( ) Clenching/Bruxing ( ) Trigeminal Neuralgia
( ) Bell's Palsy ( ) Back Pain

MEDICAL HISTORY Circle all that apply

Heart Murmur Lung Disease Tuberculosis Kidney Disease
Angina/Chest Pain Allergies Artificial Heart Valve Thyroid Disease
Heart Attack/failure Sinus problems Heart Pace maker Cold sores/Fever Blisters
Congenital Heart Disorder Asthma Blood Disease Cancer
Mitral Valve Prolapse Snoring Blood Pressure Problem OTHER
Rheumatic Fever Liver Disease Excessive Bleeding
Artificial Joints Mental Disorders Hepatitis A,B, or C Diabetes
Heart Disease Stroke Epilepsy

None of the Above

Are you under a physician's care? If so, Why Name

Are you taking ANY medications?

Please list:

Are you ALLERGIC to any medications? Penicillin Codeine Sulpha Latex Metals Acrylic

Are you pregnant or trying? Contraceptives?

Have you been in a serious accident or hospitalization?

Any other information you would like us to know?

To the best of my knowledge, all of the preceding answers and information provided are true and correct, If I every have any change in my health history, I will inform the doctor at the next appointment.

Signature

Date

**OFFICE OF DENTAL EXCELLENCE**

**KENNETH C BARNEY, D.D.S.**

**EMPLOYMENT INFORMATION**

The following is for \_\_\_\_\_ the patient \_\_\_\_\_ the person responsible for payment

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary**

Name of Insured \_\_\_\_\_ is insured a patient \_\_\_yes \_\_\_no

Insured's Birthdate \_\_\_\_\_ ID# \_\_\_\_\_

Group# \_\_\_\_\_

Insured's

Address \_\_\_\_\_

Insured's

Employer \_\_\_\_\_

Address \_\_\_\_\_

Patient's relationship to insured \_\_\_self \_\_\_spouse \_\_\_child

Insurance Plan Name and Address \_\_\_\_\_

Insurance Phone \_\_\_\_\_

**Secondary**

Name of Insured \_\_\_\_\_ is insured a patient \_\_\_yes \_\_\_no

Insured's Birthdate \_\_\_\_\_ ID# \_\_\_\_\_

Group# \_\_\_\_\_

Insured's

Address \_\_\_\_\_

Insured's

Employer \_\_\_\_\_

Address \_\_\_\_\_

Patient's relationship to insured \_\_\_self \_\_\_spouse \_\_\_child

Insurance Plan Name and Address \_\_\_\_\_

Insurance Phone \_\_\_\_\_

