



Medical Alert For Office Use

Thank you for choosing our office for you dental needs. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____ Age _____ Weight _____

Phone: Home (____) _____ Social Security # _____

Work (____) _____ Preferred contact number? Home Work Mobile

Mobile(____) _____ Male Female

Married Single Divorced Separated Widowed

Spouse's Name _____ Spouse's Employer _____

Emergency Contact _____ Phone (____) _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge. I understand it is my responsibility to inform the doctor if there is a change in the medical history.

Signature _____ **Date** _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

CITY STATE ZIP

Telephone (____) _____

Other Information

How did you hear about us? _____

What is the reason for today's visit? _____

Is there anything you would like to change about your teeth or smile? _____

Why did you leave your last dentist? _____

Patient Medical History

Physician _____ Office Phone (____) _____ Date of last visit _____

Are you currently under the care of a physician? Yes No If yes, then why? _____

Please list all medications you are currently taking: _____

Are you allergic to?		YES	NO
<input type="checkbox"/> Aspirin	Have you ever taken diet drugs Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Local Anesthetics (Novocain)	Have you taken Fosamax, Actonel or Boniva?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Codeine	Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Latex	Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Penicillin	Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sulfa	Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	Women Only:		
	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
	Nursing?	<input type="checkbox"/>	<input type="checkbox"/>
	Taking birth control?	<input type="checkbox"/>	<input type="checkbox"/>

Check (✓) if you have or have had any of the following?

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chemotherapy	Describe _____	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Artificial Heart Valves*	<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Herpes/STD's	<input type="checkbox"/> Rheumatic Fever*
<input type="checkbox"/> Artificial Joints*	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Lupus	<input type="checkbox"/> Swelling Feet/Ankle
<input type="checkbox"/> Bleeding/Blood Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mitral Valve Prolapse*	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Headaches	<input type="checkbox"/> Osteoporosis or Bone Problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur*	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers

Any other medical/health conditions we should be aware of? _____

Patient Dental History

Previous dentist? _____

Date of last dental exam? _____ Date of last cleaning? _____ Date of last X-rays? _____

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

Do you use any type of mouth rinse? _____ If yes, what type? _____

Check (✓) any of the following conditions that apply to you:

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Food impaction between teeth	<input type="checkbox"/> Sensitivity to hot, cold or sweets
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sores or growths in your mouth

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia, photos, and other medication as indicated. I authorize the dentist to release any information including the diagnosis and records of any treatment or exam rendered to me or my child during dental care to third party payers and/or health practitioners. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

Agreement to Pay for Treatment

The patient and responsible party listed below hereby agree to pay all charges submitted by the office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles (please review our financial policy below) which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for the treatment rendered even if the treatment is not considered to be a covered service by a third party insurance or payors.

I (patient and/or responsible party) realize that the failure to keep this account current may result in my being unable to receive additional services except for emergencies or when there is a prepayment for additional services. In the case of default on payment of this account, I (patient and/or responsible party) agree to pay collection incurred in attempting to collect on this amount or any future outstanding balances.

Financial Policy

Payment is due on the day services are rendered, unless prior financial arrangements have been made with our office manager.

We will submit your dental insurance at no extra charge to you, and we expect you to pay your portion of the bill on the day of service. If insurance reimbursement is not received at our office or your claim is denied, you will be billed the balance due.

My method of payment will be: Cash ___ Check ___ Credit Card ___

Broken appointments: This time that has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a \$25 cancellation fee.

PATIENTS SIGNATURE (or parent/guardian if minor)

DATE



NATHAN B. KLEIN DDS
PERSONALIZED DENTISTRY

7611 State Line Rd, Suite 310
Kansas City, MO 64114
816-822-1800

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's
Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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 using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized 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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. 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 us a letter to the address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

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 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 to 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 U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. 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 U.S. Department of Health and Human Services.