NATHAN B. KLEIN, DDS, FAGD
PERSONALIZED DENTISTRY

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

Patient Information

Name _____
FIRST LAST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Social Security # _____

Birth Date _____ E-Mail _____

Phone: Home _____ ❑ Male ❑ Female Age _____ Weight _____

Work _____ Preferred contact? ❑ Home ❑ Work ❑ Mobile ❑ E-Mail

Mobile _____ Are appointment reminders by text ok? ❑ Yes ❑ No

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Partner

Spouse's Name _____ Spouse's Employer _____

Emergency Contact _____ Emergency Phone _____

Insurance Information

Primary Dental Carrier

Subscriber Name _____ Subscriber ID or SS# _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Subscriber ID or SS# _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance & Financial Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that regardless of what benefits, if any, my dental insurance covers, I am fully responsible for all costs associated with dental treatment and services. I attest that the information on this page is correct to the best of my knowledge.

SIGNATURE_____ **DATE** _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____ Phone # _____

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, why? _____

Please list all medications you are currently taking: _____

Are you allergic to?

- ❑ Aspirin
- ❑ Local Anesthetics (Novocain)
- ❑ Codeine
- ❑ Latex
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other_____

	YES	NO
Have you ever taken diet drugs Fen-Phen/Redux?	❑	❑
Have you taken bisphosphonates? (Fosamax, Actonel, Boniva, etc)	❑	❑
Do you use tobacco?	❑	❑
Do you drink alcohol?	❑	❑
Do you use illegal drugs or abuse other substances?	❑	❑
Are you wearing contact lenses?	❑	❑
Women Only:		
Are you pregnant?	❑	❑
Nursing?	❑	❑
Taking birth control?	❑	❑

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

❑ AIDS/HIV	❑ Chemical Dependency	❑ Heart Murmur	❑ Pacemaker
❑ Anemia	❑ Chemotherapy	❑ Heart Problems	❑ Psychiatric Care
❑ Arthritis	❑ Circulatory Problems	Describe_____	❑ Radiation Treatment
❑ Artificial Heart Valves*	❑ Congenital Heart Lesions	❑ Hepatitis/Liver Disease	❑ Respiratory Disease
❑ Artificial Joints*	❑ Cortisone Treatments	❑ Herpes/STD's	❑ Rheumatic/Scarlet Fever
❑ Asthma	❑ Diabetes	❑ High or ❑ Low Blood Pressure	❑ Stroke
❑ Back Problems	❑ Endocarditis*	❑ Kidney Disease	❑ Swelling Feet/Ankle
❑ Bleeding/Blood Problems	❑ Epilepsy/Seizures	❑ Lupus	❑ Thyroid Problems
❑ Breathing problems	❑ Fainting	❑ Mitral Valve Prolapse	❑ Tonsillitis
❑ Bruise Easily	❑ Glaucoma	❑ Nervous Problems	❑ Tuberculosis
❑ Cancer	❑ Headaches	❑ Osteoporosis or Bone Problems	❑ 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 mouth rinse? ❑Yes ❑No If yes, what type? _____ Have you had braces or retainers? ❑Yes ❑No

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

❑ Bad breath	❑ Food impaction between teeth	❑ Sensitivity to hot, cold or sweets
❑ Bleeding gums	❑ Grinding teeth	❑ Sensitivity when biting
❑ Clicking or popping jaw	❑ Loose teeth or broken fillings	❑ Sores or growths in your mouth

Treatment Authorization

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent/guardian that are necessary or advisable including the use of local anesthesia, photos, medication, or other diagnostic or therapeutic procedures. I understand that although rare, any treatment utilizing a local anesthetic injection has the potential to cause temporary or permanent damage to nerves. 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 and understand it is my responsibility to inform the doctor of any changes in my medical history.

SIGNATURE_____ **DATE** _____

(parent/guardian if minor)

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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 which this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles, 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 or necessary service by a third party insurance.

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 a default of payment on this account, I agree to reimburse any collection fees incurred in attempting to collect on this amount up to 35% of the debt. I also understand I may be charged additional interest of up to 11% annually on any overdue accounts.

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.

Broken appointments: This time 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**

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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

Below 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.