



# 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: \_\_\_\_\_

		YES	NO
Are you allergic to?	Have you ever taken diet drugs Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Aspirin	Have you taken bisphosphonates? (Fosamax, Actonel, Boniva, etc)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Local Anesthetics (Novocain)	Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Codeine	Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Latex	Do you use illegal drugs or abuse other substances?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Penicillin	Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sulfa	Women Only:		
<input type="checkbox"/> Other _____	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 Murmur	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Circulatory Problems	Describe _____	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Artificial Heart Valves*	<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Artificial Joints*	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Herpes/STD's	<input type="checkbox"/> Rheumatic/Scarlet Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High or <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Endocarditis*	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Swelling Feet/Ankle
<input type="checkbox"/> Bleeding/Blood Problems	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Lupus	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Osteoporosis or Bone Problems	<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 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:

<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

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** \_\_\_\_\_  
(parent/guardian if minor)

**DATE** \_\_\_\_\_



## 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 \$40 cancellation fee.

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PATIENTS SIGNATURE (or parent/guardian if minor)

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DATE



**NATHAN B. KLEIN, DDS, FAGD**  
PERSONALIZED DENTISTRY

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## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

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\*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**

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**Below For Office Use Only**

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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.

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 unsecured protected health information. We must follow the privacy practices that are described 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.

### 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 records, and mental health records may be entitled to special confidentiality protections 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 determinations 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, conducting 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 they participate in your care or in the 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 health care decisions for 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 with products or devices;
- Notify a person of a 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.

**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 for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care 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 us a letter to the address at the end of this 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 charge you a reasonable, cost-based fee for responding to the additional requests.

**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 the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. 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 health care system, government programs, and compliance with civil rights 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 made, either by the requesting party or us, to tell you about the request or to obtain an order protecting 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 your 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 activities, 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.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or 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 your 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 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 contact 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 an amendment, we will provide 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 Web site 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 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.