PATIENT FORMS

Thank you for taking the time to fill out our patient forms. In the following pages, you will find a variety of forms that help us gather important information so we can better perform our services.

## INSTRUCTIONS:

1. Use Adobe Acrobat to digitally fill out each form to the best of your knowledge. If you do not have Acrobat please download a free version here: https://get.adobe.com/reader
2. Once you've filled out the forms, save the file to your hard drive.
3. Go to our secure file upload for your location:
   Lewisberry: http://kleindental4u.com/upload-lewisberry/
   Dillsburg: http://kleindental4u.com/upload-dillsburg/
4. Fill out the online contact form and click "Choose File".
5. Choose your completed forms from your hard drive and click "Upload and Submit Files".

*Thank you!*


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2 Barlo Circle, Suite A
Dillsburg, PA 17019

LEWISBERRY
501 Pleasant View Rd
Lewisberry, PA 17339

Klein DENTAL

# PATIENT REGISTRATION

Patient Name

Date

Birth Date

Sex M ☐ F ☐

Address, City, ST, Zip

Home Phone

Work Phone

Cell Phone

Email

Social Security Number

Marital Status Married ☐ Single ☐ Divorced ☐ Widowed ☐

Parent/Guardian Name

Employer

Employer Phone

Employer's Address

---

Spouse Name

Birthdate

Social Security Number

Spouse's Employer

Spouse's Occupation

Spouse's Work Phone

---

Insurance Subscriber's Name

Birth Date

Social Security Number

Patient Relationship Self ☐ Spouse ☐ Dependent ☐

Insurance Company

Group Number

Subscriber's Employer

Is the patient covered by another Dental Plan? Yes ☐ No ☐

*If yes, please complete the next section.*

---

Insurance Subscriber's Name

Birth Date

Social Security Number

Patient Relationship Self ☐ Spouse ☐ Dependent ☐

Insurance Company

Group Number

Subscriber's Employer

---

Whom may we thank for referring you today?


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# MEDICAL HISTORY

Physician's Name

Phone | Date of Last Visit

Pharmacy Name | Phone

Have you had any serious illness or operations? Y ☐ N ☐
*Explain*

Have you ever had a blood transfusion? Y ☐ N ☐
*Explain*

Are you currently under the care of a physician? Y ☐ N ☐
*Explain*

Do you smoke? Y ☐ N ☐

Women: Are you pregnant or nursing or could you be pregnant? Y ☐ N ☐

Allergies:

- ☐ Aspirin
- ☐ Local Anesthesia
- ☐ Codeine
- ☐ Penicillin
- ☐ Latex
- ☐ Other

Are you currently taking any of the following:

- ☐ Antibiotic
- ☐ Antihistamine
- ☐ Anticoagulants
- ☐ Antidepressant
- ☐ Asprin
- ☐ Blood Thinner
- ☐ Cholesterol
- ☐ Cortisone
- ☐ Dilantin
- ☐ Digitalis
- ☐ Insulin
- ☐ Nitroglycerin
- ☐ Sulfa
- ☐ Tranquillizers
- ☐ Other

List any medications you are currently taking, including vitamins, herbals & supplements:

Are you currently taking or have you taken Fosamax, Actonel or other osteoporosis medication? Y ☐ N ☐ If yes, Oral ☐ Injected ☐

Check all that apply:

- ☐ Anemia
- ☐ Angina
- ☐ Pectoris
- ☐ Arthritis
- ☐ Artifical Heart Valves
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Colitis
- ☐ Cortisone TX
- ☐ Cough Up Blood
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Hepatitis Type_____
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Persistent Cough
- ☐ Psychiatric Care
- ☐ Radiation
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ STDs
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swelling Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tonsilitus
- ☐ Tumors
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Other

Do you have any health problems that need further clarification? Y ☐ N ☐
*If yes, please explain:*

Does your local water municipality contain flouride? Y ☐ N ☐

What is your local water municipality?


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# DENTAL HISTORY

Date of Last Dental Visit:

Previous Dentist's Name Phone

| | | |
|---|---|---|
| Did you have radiographs taken? | Y ☐ | N ☐ |
| Did you have bitewings xrays taken? | Y ☐ | N ☐ |
| Did you have panoramic xrays taken? | Y ☐ | N ☐ |
| Do you wear a denture or partial? | Y ☐ | N ☐ |

*If yes, how old are they?*

| | | |
|---|---|---|
| Have you ever had pain in your jaw joint or near your ear? | Y ☐ | N ☐ |
| Have you had orthodontic treatment? | Y ☐ | N ☐ |
| Do you clench or grind your teeth? | Y ☐ | N ☐ |
| Does your jaw click or pop? | Y ☐ | N ☐ |
| Do you have difficulty opening wide? | Y ☐ | N ☐ |
| Does your food catch between your teeth? | Y ☐ | N ☐ |
| Do you have a bad taste or odor in your mouth? | Y ☐ | N ☐ |
| Have you ever had gum disease? | Y ☐ | N ☐ |
| Do your gums bleed while brushing or flossing? | Y ☐ | N ☐ |
| Do you have loose teeth or broken filling(s)? | Y ☐ | N ☐ |
| Have you ever taken an antibiotic before treatment? | Y ☐ | N ☐ |
| Do you have a sensitive gag reflex? | Y ☐ | N ☐ |
| Any pain in your cheeks, lips or tongue? | Y ☐ | N ☐ |
| Do you use tobacco products? | Y ☐ | N ☐ |

*If yes, how long?*

| | | |
|---|---|---|
| Is your mouth sensitive to pressure? | Y ☐ | N ☐ |
| Is your mouth sensitive to cold? | Y ☐ | N ☐ |
| Is your mouth sensitive to heat? | Y ☐ | N ☐ |
| Is you mouth sensitve to sweets? | Y ☐ | N ☐ |
| Are you happy with the appearance of your teeth, gums and smile? | Y ☐ | N ☐ |
| Would you like to discuss enhancing the appearance of your smile? | Y ☐ | N ☐ |
| Would you like to discuss whitening your teeth? | Y ☐ | N ☐ |

What type of toothbrush do you use?

Hard ☐ Medium ☐ Soft ☐ Electric ☐

How often do you brush?

How often do you floss?

What concerns would you like to discuss today?


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# AUTHORIZATION

I certify that all of the information provided on the previous pages is completed to the best of my knowledge.

Signature

Date

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to ensure the payment of benefits. I understand that I am financial responsible for all charges whether or not paid by insurance.

Signature

Date

*Payment is due in full at time of treatment unless prior arrangements have been approved.*


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# HIPAA STATEMENT

**OUR USES AND DISCLOSURES**

*We may use and share your information as we:*

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

**YOUR RIGHTS**

*When it comes to your health information, you have certain rights.*

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

*Ask us to limit what we use or share:*

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

*Choose someone to act for you:*

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.
- You can file a complaint if you if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.


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## YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

*In these cases, you have both the right and choice to tell us to:*

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

*In these cases we never share your information unless you give us written permission:*

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

## OUR USES AND DISCLOSURES

*How do we typically use or share your health information? We typically use or share your health information in the following ways:*

- Treat you. We can use your health information and share it with other professionals who are treating you.
- Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities.

*How else can we use or share your health information?*

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
- Help with public health and safety issues. We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
    - Do research
    - We can use or share your information for health research.
- Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

## CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

If you have a health information policy complaint you may contact our privacy official, Ann Enders at 717-822-0294 or annenders@kleindental4u.com.

# HIPAA CONSENT

**NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT**
I understand that, under the Health Insurance Portability & Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____
Patient Name

_____
If Responsible Party, your relationship to Patient

_____
Responsible Party Signature

Date

**OFFICE USE ONLY**
I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____
Reason: _____

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Lewisberry, PA 17339

# DENTAL X-RAYS

Dental X-rays help dentists visualize diseases of the teeth and surrounding tissue that cannot be seen with a simple oral exam. In addition, X-rays help the dentist find and treat dental problems early in their development, which can potentially save you money, unnecessary discomfort, and maybe even your life.

In adults, dental X-rays can be used to:
- Show areas of decay that may not be visible with an oral exam, especially small areas of decay between teeth
- Identify decay occurring beneath an existing filling
- Reveal bone loss that accompanies gum disease
- Reveal changes in the bone or in the root canal resulting from infection
- Assist in the preparation of tooth implants, braces, dentures, or other dental procedures
- Reveal an abscess (an infection at the root of a tooth or between the gum and a tooth)
- Reveal other developmental abnormalities, such as cysts and some types of tumors

In children, dental X-rays are used to:
- Watch for decay
- Determine if there is enough space in the mouth to fit all incoming teeth
- Determine if primary teeth are being lost quickly enough to allow permanent teeth to come in properly
- Check for the development of wisdom teeth and identify if the teeth are impacted (unable to emerge through the gums)

These images are an important tool in providing our patients with the best possible dental care.

Your co-operation in obtaining full mouth images every three years and bitewing images on a yearly basis is appreciated.

_____

Responsible Party Signature

Date


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Klein DENTAL

# APPOINTMENT POLICY

We hope to establish a long term relationship with you and look forward to providing you with optimal care at each and every visit.

A “broken” or “failed” appointment is any appointment not canceled with AT LEAST 24 hours’ notice. Broken appointments prevent us from seeing another patient in the time that was reserved for you. Please note that insurance companies WILL NOT pay broken appointment fees. These fees will have to be paid prior to any further appointment scheduling.

After your first “failed” appointment, you will be reminded of our policy by telephone. We realize people get sick, people sometimes forget, or an emergency arises. As soon as you know you cannot make the appointment, please call us.

After your second “failed” appointment you will be charged a fee of $35.00 and we will mail you a copy of our appointment policy as a reminder. We also reserve the right to limit scheduling times and the number of family members scheduled at the same time.

After your third “failed” appointment we reserve the right to charge a broken appointment fee. This fee will be half of the amount of the services that were scheduled for you.

After your fourth “failed” appointment you will be dismissed from the practice. Should that occur, we will provide you with emergency care for up to 30 days and forward any necessary records to your new dental provider.

We make every effort to schedule you at a time that is most convenient while allowing adequate time for your necessary services. This time is reserved just for you. Please extend to us, and the other patients, the courtesy of keeping your appointments or, if necessary to reschedule, allowing adequate notice.

I have read, understand, and agree to the above Appointment Policies.

_____

Responsible Party Signature

Date


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# INSURANCE POLICY

Dear Patient:

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception – dental insurance was not designed to pay for all dental care. Most contracts have limits and / or various degrees of co-payment.

All levels of payment by insurance companies, including allowed fees, usual, customary and reasonable (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company, the employer and the patient, whom bears the ultimate financial responsibility.

We hope this information has been helpful. Please take time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask our front desk staff for clarification on services, billing and insurance.

Sincerely,

Klein Dental


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# FINANCIAL POLICY

**FINANCIAL POLICY**
We are committed to providing you with the best possible care and would be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

If you do not have insurance we expect payment in full for all treatment at the time of service, unless other arrangements have been made. We accept cash, checks, Visa, Master Card and Discover. We also offer interest free financing through Care Credit.

**REGARDING INSURANCE**
If you have insurance, we will help you receive maximum benefits. Your insurance claim will be completed and submitted if we are provided with all pertinent insurance plan information. It is your responsibility to verify that your policy is in force on your date of service and that you are eligible for the treatment proposed.

Insurance is an agreement between you and your insurance company. We submit claims as a courtesy to you, our patient. We will not become involved in disputes between you and your insurance company regarding deductible, co-payments, non-covered charges, secondary coverage, etc., other than to supply necessary factual information. Deductibles and co-payments are required at the time of service. You are responsible for the prompt payment of your account. If payment is not received from your insurance company within 90 days, the balance on the account becomes your responsibility.

**AGREEMENT**
I have read the above Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance. I understand and agree that a monthly interest charge of 1.5% of my balance may be added to my account if my balance is not paid in full within 30 days. I understand and agree that my account may be turned over to a collection agency if not paid in full after the third billing and that a 25% collection fee will be added to my account.

_____
Responsible Party Signature

Date


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Dillsburg, PA 17019

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2 Barlo Circle
Dillsburg, PA 17019
717.432.9762
dillsburg@kleindental4u.com

501 Pleasant View Road
Lewisberry, PA 17339
717.938.1415
lewisberry@kleindental4u.com

Date _____/_____/_____ Patient Name: _____

**Facial Cosmetic Services Questionnaire**

Would you be interested in more information on any of the following?

- ◯ Veneers / Cosmetic Dentistry
- ◯ Amalgam Removal by Changing Silver Fillings to White Fillings (Porcelain or Composite)
- ◯ Botox

  The areas that Botox is commonly used for are smoothing of facial wrinkles on the forehead, between the eyes (glabellar region), and around the corners of the eyes (crow's feet) (Figures 1&2) and around the lips. Botox has important clinical uses as an adjunct in TMJ and bruxism cases, and for patients with chronic TMJ and facial pain. Botox is also used to complement esthetic dentistry cases, as a minimally invasive alternative to surgically treating high lip line cases, denture patients who have trouble adjusting to new dentures, lip augmentation, and has uses in orthodontic cases where retraining of the facial muscles is necessary.

- ◯ Dermal Filler

  Dermal fillers will volumize creases and folds in the face in areas that have lost fat and collagen as we age. After age 30, we all lose approximately 1% of hyaluronic acid from our bodies. Hyaluronic acid is the natural filler substance in your body. The face starts to lack volume and appears aged with deeper nasolabial folds, unaesthetic marionette lines, a deeper mentalis fold, the lips start to thin, and turning down the corners of the lips (Figure 3). Hyaluronic acid fillers such as Restylane and Juvederm are then injected extraorally right underneath these folds to replace the volume lost which creates a younger look in the face (Figure 4). Dermal fillers can be used for high lip line cases, asymmetrical lips around the mouth, lip augmentation, and completing cosmetic dentistry cases by creating a beautiful, young-looking frame around the teeth. The effect of dermal fillers typically last anywhere from 6 to 12 months at which point the procedure needs to be repeated.

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dillsburg@kleindental4u.com

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lewisberry@kleindental4u.com

**Patient Name:** **DOB:**

**Address:**

I give Klein Dental my permission to share dental, personal, business, insurance and any other information they may have with the individuals listed below:

**Signature of Authorized Person** **Date:**