KLEIN DENTISTRY

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Welcome to our practice! We are pleased that you have chosen us to meet your dental needs. Our mission is to serve our patients with compassion and empathy while providing excellent comprehensive dental care in a friendly, safe, and relaxed environment.

Getting to know you personally and assessing your dental needs, is our main objective during your initial visit to our office. **Please help us give you the time and attention you deserve by completing the patient registration, medical history and privacy notice forms BEFORE YOU ARRIVE.**

As soon as possible, please contact your previous dental office and have ALL CURRENT DENTAL RADIOGRAPHS and pertinent treatment notes transferred to our office. We want this transition to be as smooth as possible for you, so please call us if you need assistance. Patients are encouraged to start this process several weeks before the initial visit to allow sufficient time for duplication and shipping. All necessary radiographs will be taken during your initial visit unless we have received current radiographs of diagnostic quality from your previous dental office.

Please bring your insurance card, the name of the employer and the social security number of the person who is the insurance subscriber. We will be happy to assist you in any way we can with your insurance. Please remember that regardless of dental insurance coverage, payment remains your personal responsibility. Insurance co-payments, fees for non-covered services and all other payments are expected at the time of your appointment. If you are unable to pay at the time of service, financial arrangements must be made prior to your appointment.

During your first visit, we will conduct a thorough examination. This examination will include a complete head and neck examination, a thorough examination of your mouth, teeth and gums, along with any necessary x-rays. Afterward, we will discuss the findings of your examination and work together to create a plan the best meets your individual needs and goals.

We recognize the value of your time. Except in emergency situations, you can expect us to be on time for you. We appreciate the same courtesy. If for some reason you cannot make your appointment, we ask that you notify us at least 48 hours in advance.

Our office is located near the NE corner of Ivanrest and 44th Street. Parking is available near the front entrance.

Should you have any questions, please call. We are looking forward to a relaxed and pleasant visit with you.

Sincerely,

Douglas R. Klein, D.D.S.

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Dental Insurance or Dental **Assistance**?

Dental Benefits are **NOT** really *Insurance* in the classic sense.

*If you have needs other than healthy cleanings, your care **will** require an investment beyond what your "insurance" will cover. Your benefits will assist you in the maintenance of your dental health but were never designed to be all you need.*

It's not news that employers have reacted to the rising costs of health care benefits by shopping carefully for the insurance policies that they offer their employees. Benefits are down, restrictions and exclusions are up. Our patients share their resulting frustration with us every day. Adding to the frustration is the fact that dental benefits are often represented as being comparable to other types of insurance. "Insurance", by definition, is protection against unpredictable or catastrophic loss. But most dental insurance policies specifically *exclude* extraordinary needs. The things offered as benefits are not only predictable, but expected, such as routine exams, x-rays, healthy cleanings, etc. Further, policies that do offer a benefit of other common services, such as crowns and treatment for gum disease, provide them at a much lower percentage of the actual cost of providing that care, and with a low dollar limit per year.

Your dental benefit plan is an excellent maintenance assistance program that will help you protect your investment in your dental health, and we're happy you have that assistance!

Another common misrepresentation is that dental "insurance" covers all of the things that you need. We believe this can be a danger to your health, because **it implies that *if it isn't covered, you don't need it*.** Insurance companies are in business to make money. This is no secret and it's not bad or wrong. Their responsibility to their shareholders is to provide the benefits they can while still creating profit within the investment your employer has chosen to make in dental health. You cannot count on a dental benefit plan to determine what you need; that's your responsibility. It's our responsibility to advise you regarding your health. The fact is, unless you have excellent dental health, your needs will require that you make an investment.

We invest in what we value. Home improvement, education, vacations, are all examples of things we pay for, by choice, because we value them. We don't presume to know where dental health fits in your value system. That's for you to decide. It's important for us that you know we think you're worth the investment, and we'll work with your benefit plan to see that you receive the maximum benefits in assisting you with the maintenance of your health.

We work with and welcome ANY questions about your dental benefit plan.

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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 (Jan. 1, 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.

Michigan's Dental Patient Consent Law: We are required by Michigan Law to obtain your written consent prior to making certain disclosures of your health information.

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 a 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 as required to 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, the fee is $5.00 for each page or $35.00 per hour for staff time to locate and copy your health information, plus postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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.

Restriction: 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.

Contact Officer: Sherry Hamilton

Telephone: 616-538-4960 Email: info@kleindentistry.com

Address: 3185 Macatawa Drive, Suite C, Grandville, MI 49418

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Patient Acknowledgement

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of out Notice of Privacy Practices. This notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as a part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____	_____	_____
Patient Signature	Patient Name (please print)	Date

FOR OFFICE USE ONLY

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement.

_____

An emergency situation prevented the patient from signing the Acknowledgement.

_____	_____	_____
Office Personnel (print name)	Office Personnel (signature)	Date

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Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be the type listed above.

I hereby authorize Dr. Klein's office to take photographs and x-rays my face, jaws, mouth, and teeth.

I understand that the photographs and/or x-rays will be used as a record of my care, and may be used without compensation, financial or otherwise, for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines). These photos may also be used on internet and social media sites such Facebook, Instagram and Twitter. *Any full face (or identifying) photos taken are only used for professional purposes and will never be published online without the patient's full consent.*

I further understand that if the photographs and/or x-rays are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

_____	_____	_____
Patient Signature	Patient Name (please print)	Date

FOR OFFICE USE ONLY

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Consent.

_____

An emergency situation prevented the patient from signing the Consent.

_____	_____	_____
Office Personnel (print name)	Office Personnel (signature)	Date

TIME 11:27 AM DATE 1/29/2017

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Cellular #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

MEDICAL HISTORY QUESTIONNAIRE (2018.08)

Patient Name: Birth Date: Date Created:

Your health conditions and medications can be critically important to your dental care. Thank you for thoroughly answering the following questions.

In order to help us provide you the MOST COMFORTABLE dental experience, please select ALL that apply.

Autism Spectrum Disorder	Yes No	Back and/or Neck Pain	Yes No	Dental Anxiety	Yes No
Extremely Sensitive Teeth	Yes No	Hearing Impairment	Yes No	Cognitive Impairment	Yes No
Physical Impairment	Yes No	Vertigo	Yes No	Medical Issue with Past Dental Care	Yes No

If you answered YES above, please let us know how we can make your appointments comfortable for you.

Please mark YES to all of the following dental conditions or treatments you are currently undergoing, or have previosuly undergone.

Wisdom Teeth Removed	Yes No	Orthodontic Treatment	Yes No	Jaw Surgery	Yes No	Gum Disease	Yes No
TMJ Concerns	Yes No	Bite Splint/Night Guard	Yes No	Sleep Apnea	Yes No	Missing Teeth	Yes No
Teeth Clenching/Grinding	Yes No	Snoring	Yes No	Dental Implant	Yes No	Full or Partial Dentures	Yes No

If you answered YES to SLEEP APNEA or SNORING, have you undergone a sleep study? Yes No If yes

If you answered YES to SLEEP APNEA or SNORING, do you use a C-PAP machine or Sleep Appliance? Yes No If yes

If you answered YES to any of the above, please provide more detail.

Are you allergic or sensitive to any of the following?

Acrylic	Yes No	Amoxicillin/Penicillin	Yes No	Codeine	Yes No	Food and/or Nuts	Yes No
Latex	Yes No	Local Anesthetic	Yes No	Metal	Yes No	Sulfa Drugs	Yes No
Topical Anesthetic	Yes No	Other	Yes No				

If you answered YES to any questions, please provide more detail.

Do you have a primary care physician? Please provide name and phone number.	Yes No	If yes
Do you know when you had your last complete physical examination? Please provide date.	Yes No	If yes
Are you currently seeing a specialist physician? Please provide name, phone number, and condition.	Yes No	If yes
Have you been hospitalized, had a serious illness, or had surgery in the last 12 months? Please describe.	Yes No	If yes
Have you ever undergone radiation treatment to your head and/or neck?	Yes No	If yes
Do you have any artificial joints? If yes, when? And which joint?	Yes No	If yes
Have you ever been advised to take prophylactic antibiotics before a dental appointment?	Yes No	If yes
Do you consume alcohol?	Yes No	If yes
Do you use tobacco in any form?	Yes No	If yes
Do you use e- cigarettes or "vape"?	Yes No	If yes
Do you use marijuana or other recreational drugs?	Yes No	If yes

Do you currently have or have you ever had any of the following medical conditions? Please check ALL that apply.

Angina Yes No	Congenital Heart Defect Yes No	Congestive Heart Failure Yes No	Coronary Artery Bypass Yes No
Dizziness/Fainting Yes No	Heart Attack Yes No	Heart Disease Yes No	Heart Murmur Yes No
Heart Valve Repair/Replacement Yes No	High Blood Pressure Yes No	High Cholesterol Yes No	Mitral Valve Prolapse Yes No
Pacemaker Yes No	Rheumatic Heart Disease Yes No	Stroke Yes No	Arthritis Yes No
Asthma Yes No	Autoimmune Disease Yes No	Blood Disease Yes No	Cancer Yes No
Chemotherapy Yes No	Diabetes Yes No	Gastric Reflux (GERD) Yes No	Glaucoma Yes No
Hepatitis Yes No	Cold Sores Yes No	HIV/AIDS Yes No	Kidney Disease Yes No
Liver Disease Yes No	Migraines Yes No	Osteoporosis Yes No	Organ Transplant Yes No
Sinus Problems Yes No	Sjogren's Syndrome Yes No	Thyroid Disease Yes No	Crohn's Disease Yes No
Anxiety Yes No	Depression Yes No	Seizures (Epilepsy) Yes No	Bulimia/Eating Disorder Yes No

If you answered YES to any of the above, please provide more detail.

Are you CURRENTLY taking, or have you TAKEN IN THE PAST YEAR, any of the following medications? Please check ALL that apply.

Acid Reducer Medication Yes No	Allergy Medication Yes No	Antianxiety Medication Yes No	Antidepressant Medication Yes No
Asthma Medication Yes No	Blood Pressure Medication Yes No	Blood Thinner Medication Yes No	Cholesterol Medication Yes No
Diuretic Medication Yes No	Heart Medication Yes No	Muscle Relaxer Medication Yes No	Prescription Pain Medication Yes No
Sleep Medication Yes No	Steroid Medication Yes No	Thyroid Medication Yes No	Vitamins/Supplements Yes No
Seizure Medication Yes No			

HAVE YOU EVER used a BISPHOSPHONATE medication for OSTEOPOROSIS (Fosamax, Boniva, Yes No If yes

If you answered YES to any of the above, please list the name and dosage of ALL the medications, vitamins and/or supplements you are CURRENTLY taking.

WOMEN...are you currently

Taking oral contraceptives?	Yes No
Receiving Hormone Thearpy?	Yes No
Nursing?	Yes No

Pregnant? Yes No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____