KLEIN DENTISTRY

prevent - restore - rejuvenate

# NEW PATIENT REGISTRATION FORMS

## Fill out these forms to make your first appointment faster!

There are two ways you can complete the forms:

**OPTION 1**

Download the document to your computer, fill in the fields on your computer, save the PDF using the patient's name, then upload it on our secure website at: https://kleindentistry.com/forms

The forms work best with Adobe Acrobat on a computer. Mobile devices don't work as well.

**OPTION 2**

Print out the forms on your home printer, fill them in with a pen and bring them to your first appointment.

www.KleinDentistry.com/forms

3185 Macatawa Drive SW, Suite C
Grandville MI 49418
616.538.4960

Rev 3/27/2020

# PATIENT REGISTRATION

Date

Patient Name *(First, MI, Last)*:

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

## Patient Information

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Ext: Cell Phone:

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ Email me appointment correspondences

☐ Text me appointment correspondences (provide cell above)

Sex: ☐ Male ☐ Female

Employment: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Student: ☐ Full Time ☐ Part Time

## Responsible Party ( if someone other than patient )

Name (First, MI, Last):

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Ext: Cell Phone:

Birth Date: Soc Sec: Drivers Lic:

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

## Primary Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

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

Employer ID: Carrier ID:

## Secondary Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

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

Employer ID: Carrier ID:

# MEDICAL HISTORY

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

Today's Date:

Patient Name *(First, MI, Last)*: Patient Birthdate:

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 previously undergone.

| | | | | | |
|---|---|---|---|---|---|
| **Wisdom Teeth Removed** | ◯ Yes ◯ No | **Orthodontic Treatment** | ◯ Yes ◯ No | **Jaw Surgery** | ◯ Yes ◯ No |
| **TMJ Concerns** | ◯ Yes ◯ No | **Bite Splint/Night Guard** | ◯ Yes ◯ No | **Sleep Apnea** | ◯ Yes ◯ No |
| **Teeth Clenching/Grinding** | ◯ Yes ◯ No | **Snoring** | ◯ Yes ◯ No | **Dental Implant** | ◯ Yes ◯ No |
| **Gum Disease** | ◯ Yes ◯ No | **Missing Teeth** | ◯ 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, Describe:

If you answered YES to SLEEP APNEA or SNORING, do you use a C-PAP machine or Sleep Appliance?

◯ Yes ◯ No If Yes, What Type?

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

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

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

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

| | | | | | |
|---|---|---|---|---|---|
| **Angina** | ◯ Yes ◯ No | **Rheumatic Heart Disease** | ◯ Yes ◯ No | **Kidney Disease** | ◯ Yes ◯ No |
| **Congenital Heart Defect** | ◯ Yes ◯ No | **Stroke** | ◯ Yes ◯ No | **Liver Disease** | ◯ Yes ◯ No |
| **Congestive Heart Failure** | ◯ Yes ◯ No | **Arthritis** | ◯ Yes ◯ No | **Migraines** | ◯ Yes ◯ No |
| **Coronary Artery Bypass** | ◯ Yes ◯ No | **Asthma** | ◯ Yes ◯ No | **Osteoporosis** | ◯ Yes ◯ No |
| **Dizziness/Fainting** | ◯ Yes ◯ No | **Autoimmune Disease** | ◯ Yes ◯ No | **Organ Transplant** | ◯ Yes ◯ No |
| **Heart Attack** | ◯ Yes ◯ No | **Blood Disease** | ◯ Yes ◯ No | **Sinus Problems** | ◯ Yes ◯ No |
| **Heart Disease** | ◯ Yes ◯ No | **Cancer** | ◯ Yes ◯ No | **Sjogren's Syndrome** | ◯ Yes ◯ No |
| **Heart Murmur** | ◯ Yes ◯ No | **Chemotherapy** | ◯ Yes ◯ No | **Thyroid Disease** | ◯ Yes ◯ No |
| **Heart Valve Repair** | ◯ Yes ◯ No | **Diabetes** | ◯ Yes ◯ No | **Crohn's Disease** | ◯ Yes ◯ No |
| **Heart Valve Replacement** | ◯ Yes ◯ No | **Gastric Reflux (GERD)** | ◯ Yes ◯ No | **Anxiety** | ◯ Yes ◯ No |
| **High Blood Pressure** | ◯ Yes ◯ No | **Glaucoma** | ◯ Yes ◯ No | **Depression** | ◯ Yes ◯ No |
| **High Cholesterol** | ◯ Yes ◯ No | **Hepatitis** | ◯ Yes ◯ No | **Seizures (Epilepsy)** | ◯ Yes ◯ No |
| **Mitral Valve Prolapse** | ◯ Yes ◯ No | **Cold Sores** | ◯ Yes ◯ No | **Bulimia/Eating Disorder** | ◯ Yes ◯ No |
| **Pacemaker** | ◯ Yes ◯ No | **HIV/AIDS** | ◯ 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 | **Blood Pressure Medication** | ◯ Yes ◯ No | **Muscle Relaxer Medication** | ◯ Yes ◯ No |
| **Allergy Medication** | ◯ Yes ◯ No | **Blood Thinner Medication** | ◯ Yes ◯ No | **Prescription Pain Meds** | ◯ Yes ◯ No |
| **Anti-anxiety Medication** | ◯ Yes ◯ No | **Cholesterol Medication** | ◯ Yes ◯ No | **Sleep Medication** | ◯ Yes ◯ No |
| **Antidepressant Medication** | ◯ Yes ◯ No | **Diuretic Medication** | ◯ Yes ◯ No | **Steroid Medication** | ◯ Yes ◯ No |
| **Asthma Medication** | ◯ Yes ◯ No | **Heart Medication** | ◯ Yes ◯ No | **Thyroid Medication** | ◯ Yes ◯ No |
| **Seizure Medication** | ◯ Yes ◯ No | **Vitamins/Supplements** | ◯ Yes ◯ No | | |

**HAVE YOU EVER use a BISPHOSPHONATE medication of OSTEOPOROSIS (Fosamax, Boniva, Actonel, Reclast)?**

◯ Yes ◯ No If Yes, please describe:

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

WOMEN....are you currently:

| | | | |
|---|---|---|---|
| **Taking Oral Contraceptives** | ◯ Yes ◯ No | | |
| **Receiving Hormone Therapy** | ◯ Yes ◯ No | | |
| **Nursing** | ◯ Yes ◯ No | | |
| **Pregnant** | ◯ Yes ◯ No | If Yes, What is Your Due Date? | |

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. By electronically signing this form, you agree to the conditions stated above.

**Patient Name** ***(sign or type your name)*** **Date**

# HIPAA Authorization

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we provided you a copy of our Notice of Privacy Practices. This notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

**As discussed in our Notice of Privacy Practices, we will use our professional judgment in deciding with whom to discuss your health care and payment information.**

**Click to view PDF of our Notice of Privacy Practices.**

If you wish to restrict the sharing of your private health care information beyond the guidelines detailed in our Notice of Privacy Practices, this Consent Section allows you to specifically identify with whom we may or may not discuss your health care or payment information.

☐ You may discuss my health care or payment information with the following individuals:

☐ Please do not discuss my health care or payment information with the following individuals:

☐ Please do not discuss my health care or payment information with anyone.

By physically or electronically signing below, I acknowledge that Klein Dentistry has provided me a copy of their Notice of Privacy Practices.

**Patient Name** ***(sign or type your name)*** **Date**

# Failed Treatment Reservation Policy

Each time a patient fails to attend a reserved treatment time without providing adequate notice, another patient is prevented from receiving care. Therefore, when a patient fails to attend their reserved treatment time or cancels their reserved treatment time within 24 hours of the reservation, it is considered a **Failed Reservation**.

Klein Dentistry will afford each patient one (1) **Failed Reservation** without charge. For subsequent occurrences, Klein Dentistry reserves the right to charge a fee of $100.00 per occurrence. In order to schedule subsequent reservations, my account balance, including any **Failed Reservation** charges, must be paid in full.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By electronically or physically signing below, I acknowledge that I have received this notice and understand this policy.

_____ _____

**Patient Name** ***(sign or type your name)*** **Date**

# Photography Policy

Klein Dentistry routinely utilizes digital photography of patients' face, mouth and teeth as a record of care, as well as to aid in diagnosis. As such, these photos may be shared with other providers who are directly or indirectly involved in their care.

Klein Dentistry will obtain written consent for use of patient photographs for all purposes not stated herein.

By electronically or physically signing below, I acknowledge that I have received this notice and understand this policy.

_____ _____

**Patient Name** ***(sign or type your name)*** **Date**