# PATIENT REGISTRATION FORM

(This information is necessary for our files and your health and will be considered **CONFIDENTIAL**)

Last Name _____ First _____ Mi _____ M F

I prefer to be called: _____ Birthday: ___/___/___ Age: _____ Single Married Divorced

Social Security #: _____ Drivers License#: _____ Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: ( ) _____ Work Phone #: ( ) _____ Ext.: _____ Cell #: _____

Whom may we Thank for referring you? _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

If patient is a student-Name of school: _____

## Neighbor or Relative not living with you

His/Her Name: _____ Relation: _____ Home Phone #.: ( ) _____

Address: _____ Work Phone #.: ( ) _____
Street City State Zip

## Person Responsible for Account if other than Yourself

Name: _____ Relation: _____ Home Phone #.: ( ) _____

Employer: _____ Work Phone #: _____ Ext.: _____ Driver's License #: _____

Billing Address: _____
Street City State Zip

## Spouse/Parent Information

Name: _____ Birthday: ___/___/___ Social Security #.: _____

Employer: _____ Work Phone #: ( ) _____ Ext.: _____ Driver's License #: _____

## Dental Insurance Information

**Primary Insurance**

Insurance Co. Name: _____ Phone #: ( ) _____ Group#: _____

Insurance Co. Address: _____
Street City State Zip

Insureds' Name: _____ SS#: _____ Insureds' Birthday.: ___/___/___ Relation: _____

Insureds' Employer: _____ Employer Address: _____
Street City State Zip

**Secondary Insurance**

Insurance Co. Name: _____ Phone #: ( ) _____ Group#: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Name: _____ SS#: _____ Insured's Birthday.: ___/___/___ Relation: _____

Insured's Employer: _____ Employer Address: _____
Street City State Zip

**PATIENT RESPONSIBLE FOR FEES:** I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid within 30 days of the date on which examinations are provided. I hereby authorize that the payment from any insurance company due me be paid directly to Stephen M. Klein, D.D.S. In the event of default in payment patient or party responsible for fees agree to pay any and all costs of suit, collection and attorney's fees.

**PLEASE BE ADVISED THAT THE POLICY OF THIS OFFICE LIMITS ALL ACCOUNTS TO TERMS OF 90 DAYS WITHOUT A LATE PAYMENT CHARGE. A LATE CHARGE OF 1 1/2% (18% ANNUAL PERCENTAGE RATE) MAY BE APPLIED TO ALL DELINQUENT ACCOUNTS.**

Signature - Patient or Responsible Party _____ Date _____

# HEALTH QUESTIONNAIRE

**MEDICAL HISTORY**

Name of Physician_____ Phone: _____

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a physician? Y N Please explain: _____

Are you taking any prescription/over the counter drug(s)? Y N Please explain: _____

Please list each one: _____

Have you ever had any serious illness or operation? Y N Please explain:_____

**DO YOU HAVE TO BE PREMEDICATED BEFORE DENTAL TREATMENT?** Y N **HAVE YOU EVER TAKEN PHEN-FEN? Y N**

**IF SO, HAVE YOU CONSULTED YOUR M.D. REGARDING HEART CONDITION.** Please explain: _____

**FOR WOMEN**

Are you taking birth control pills? Y N Are you pregnant? Y N Are you nursing? Y N

**HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | Heart Attack/Stroke | Y | N | High or Low Blood Pressure | Y | N | Ulcers |
| Y | N | Cancer/Chemotherapy | Y | N | Fever Blister | Y | N | Congenital Heart Defect |
| Y | N | Heart Murmur | Y | N | Severe/Frequent Headaches | Y | N | Radiation Treatment |
| Y | N | Rheumatic Fever | Y | N | Cardiac Pacemaker | Y | N | Asthma |
| Y | N | Heart Surgery/Pacemaker | Y | N | Psychiatric Problems | Y | N | Difficulty Breathing |
| Y | N | Shingles | Y | N | Epilepsy/Seizures/Fainting | Y | N | Hospitalized for any reason |
| Y | N | Mitral Valve Prolapse | Y | N | Diabetes | Y | N | Hepatitis |
| Y | N | Kidney Problems | Y | N | Drug/Alcohol Abuse | Y | N | Blood Transfusion |
| Y | N | Artificial Bones/Joints | Y | N | Venereal Disease | Y | N | Emphysema |
| Y | N | Artificial Valves | Y | N | Hemophilia/Abnormal Bleeding | Y | N | HIV+/AIDS |
| Y | N | Sinus Problems | Y | N | Glaucoma | Y | N | Anemia |
| Y | N | Tuberculosis (TB) | Y | N | Colitis | Y | N | Arthritis |

Please list any medical condition(s) that you have ever had: _____

**Are you allergic to any of the following drugs or materials?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | Penicillin | Y | N | Tetracycline | Y | N | Aspirin |
| Y | N | Erythromycin | Y | N | Codeine | Y | N | Antibiotics |
| Y | N | Sulfa Drugs | Y | N | Latex | Y | N | Other |

Please list any other drugs that you are allergic to:_____

**MEDICAL HISTORY**

Previous Dentist_____ Phone: _____

Dental Complaint at this moment? _____

Have you ever had any unfavorable reaction from a local anesthetic? _____

Have you ever had any serious trouble associated with any previous dental treatment? _____

Explain: _____

How long since last dental X-Rays of your entire mouth? _____ How long since last dental treatment? _____

Do you have or do you use any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | Bleeding gums | Y | N | Complications from extractions | Y | N | Water jet device |
| Y | N | Food impaction | Y | N | Periodontal (gums) treatment | Y | N | Fluoride supplements |
| Y | N | Clenching or grinding | Y | N | Orthodontic treatment | Y | N | Fluoride treatments |
| Y | N | Bad breath | Y | N | Cigarettes, pipe or cigar smoking | | | |
| Y | N | Unpleasant taste | Y | N | Dental floss | | | |

**CONSENT FOR TREATMENT:** I hereby authorized to the dentist(s) in charge of the care of the patient whose name appears on this form to administer any treatment, or to administer such anesthetic, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such dental operations or procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed _____ Date_____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Stephen M. Klein, DDS
General Family Dentistry

# DENTAL FINANCIAL POLICY

## Insurance Coverage

**The following financial policy applies to all patients who have insurance coverage.** Please carefully read and sign this agreement providing you agree with it. Let our finance staff know if you have any questions.

1) We will be happy to bill your insurance company for your care providing you give us all the information we need. Even though you have insurance coverage, remember that paying for your treatment is your personal responsibility. We will verify your insurance benefits by contacting the insurance company. You will need to sign an "Assignment of Rights and Benefits" so we can accept your insurance coverage.

2) You will need to pay your portion of the charges as you go. This includes the annual deductible, co-payment, and charges your insurance company refuses to pay. We accept the following forms of payment:

 Check  Cash  Visa  MasterCard

3) Occasionally, an insurance company will send a payment to a patient. If this occurs, bring us the check and the attached stub. The information on the stub is very important. Also, your insurance company may request additional information from you. They will not pay your claim until they receive the information, so please send any requested information immediately.

By signing below you agree to the terms of this policy.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name<br>(Parent/guardian if patient is a minor) | Signature | Date |
| _____ | _____ | _____ |
| Staff Member Name | Signature | Date |

Stephen M. Klein, DDS
General Family Dentistry

Patient Name: _____

## Cancellation Policy Fee

We require **48 hours notice of cancellation** for your scheduled procedure (cleaning, treatment, emergency) appointment. When a patient doesn't show for his/her scheduled appointment, another patient loses an opportunity to be seen. Therefore, a fee of $50.00 will be charged per incident. This fee is not covered by insurance carriers and will be your responsibility to pay. Your cooperation and consideration are appreciated as we institute this policy to minimize the disruption of work flow as well as accommodating those in need of our services.

A scheduled appointment is a commitment of time between the Doctor and the patient. We have reserved that time *JUST FOR YOU*. When appointments are missed or cancelled, that time is lost.

It is now our policy that with less than 48 hours notice on a change of commitment, a charge will be considered and could be applied to your account.

If you have any questions regarding this or any of our policies or procedures, as always, we are more than happy to discuss them with you

By signing below, I understand that I will be responsible for payment of $50.00 should I not provide adequate notice of cancellation.

Signature _____

Date_____

# Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Stephen M. Klein, DDS, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you. You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 515F, Washington, DC 20201), by email (OCRComplaint@hhs.gov) or online (www.hhs.goviocr/privacythipaa/complaints). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Dr. Stephen M. Klein, at (661) 871-0780 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

## Acknowledgment

I have received a copy of the Stephen Klein, DDS Notice of Privacy Practices. Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____