DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

SSN _____

Patient Name _____
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip _____

Email _____

Sex ☐ M ☐ F

Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for____years

Patient Employer/School _____

_____

Occupation _____

Employer/School Phone _____

Whom may we thank for referring you? _____

_____

PHONE NUMBERS

Home _____ Cell Phone _____

Work _____ Ext _____

Spouse's Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT
(Specify someone who does not live in your household)

Name _____ Relationship _____

Home _____ Cell Phone _____

Work _____ Ext _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Is patient covered by additional/secondary insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SSN _____

Relationship to Patient _____

Primary Insurance Co. _____

Group # _____

ID Number _____

Secondary Insurance Co. _____

Group # _____

ID Number _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____

all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print name of Patient, Parent, Guardan or Personal Representative

_____ _____
Date Relationship to Patient

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐Yes ☐No	
Bleeding gums	☐Yes ☐No	
Blisters on lips or mouth	☐Yes ☐No	
Burning sensation on tongue	☐Yes ☐No	
Chew on one side of mouth	☐Yes ☐No	
Cigarette, pipe, or cigar smoking	☐Yes ☐No	
Clicking or popping jaw	☐Yes ☐No	
Dry mouth	☐Yes ☐No	
Fingernail biting	☐Yes ☐No	
Food collection between teeth	☐Yes ☐No	
Foreign objects	☐Yes ☐No	
Grinding teeth	☐Yes ☐No	
Gums swollen or tender	☐Yes ☐No	
Jaw pain or tiredness	☐Yes ☐No	
Lip or cheek biting	☐Yes ☐No	
Loose teeth or broken fillings	☐Yes ☐No	
Mouth breathing	☐Yes ☐No	
Mouth pain, brushing	☐Yes ☐No	
Orthodontic treament	☐Yes ☐No	
Pain around ear	☐Yes ☐No	
Periodontal treatment	☐Yes ☐No	
Sensitivity to cold	☐Yes ☐No	
Sensitivity to heat	☐Yes ☐No	
Sensitivity to sweets	☐Yes ☐No	
Sensitivity when biting	☐Yes ☐No	
Sores or growth in your mouth	☐Yes ☐No	

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV ☐Yes ☐No	Heart Problems ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Anemia ☐Yes ☐No	Hepatitis Type _____ ☐Yes ☐No	Tumor or growth on head or neck ☐Yes ☐No
Arthritis, Rheumatism ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	
Artificial Heart Valves ☐Yes ☐No	Jaundice ☐Yes ☐No	Ulcer ☐Yes ☐No
Artificial Joints ☐Yes ☐No	Jaw Pain ☐Yes ☐No	Weight Loss, unexplained ☐Yes ☐No
Asthma ☐Yes ☐No	Kidney Disease ☐Yes ☐No	Do you wear contact lenses? ☐Yes ☐No
Back Problems ☐Yes ☐No	Liver Disease ☐Yes ☐No	**Women:**
Bleeding abnormally, with extractions or surgery ☐Yes ☐No	Low Blood Pressure ☐Yes ☐No	Are you pregnant? ☐Yes ☐No
	Mitral Valve Prolapse ☐Yes ☐No	Due Date _____
Blood Disease ☐Yes ☐No	Nervous Problems ☐Yes ☐No	Are you nursing? ☐Yes ☐No
Cancer ☐Yes ☐No	Pacemaker ☐Yes ☐No	Taking birth control pills? ☐Yes ☐No
Chemical Dependency ☐Yes ☐No	Psychiatric Care ☐Yes ☐No	
Chemotherapy ☐Yes ☐No	Radiation Treatment ☐Yes ☐No	
Circularity Problems ☐Yes ☐No	Respiratory Disease ☐Yes ☐No	
Cold Sores ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No	
Congenital Heart Lesions ☐Yes ☐No	Scarlet Fever ☐Yes ☐No	
Cortisone Treatments ☐Yes ☐No	Shortness of Breath ☐Yes ☐No	
Coup, persistent or bloody ☐Yes ☐No	Sinus Trouble ☐Yes ☐No	
Diabetes ☐Yes ☐No	Skin Rash ☐Yes ☐No	
Emphysema ☐Yes ☐No	Special Diet ☐Yes ☐No	
Epilepsy ☐Yes ☐No	Stroke ☐Yes ☐No	
Fainting or dizziness ☐Yes ☐No	Swollen Feet or Ankles ☐Yes ☐No	
Glaucoma ☐Yes ☐No	Swollen Neck Glands ☐Yes ☐No	
Headaches ☐Yes ☐No	Thyroid Problems ☐Yes ☐No	
Heart Murmur ☐Yes ☐No	Tonsillitis ☐Yes ☐No	

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

_____

Pharmacy Name _____ Phone _____

ALLERGIES

☐ Aspirin ☐ Penicillin
☐ Barbiturates (sleeping pills) ☐ Sulfa
☐ Codeine ☐ Other:
☐ Iodine _____
☐ Latex _____
☐ Local Anesthetic _____

UPDATES (To be filled in at future appointments)

Has there been any changes in your health since your last dental appointment? _____

For what conditions? _____

Are you taking any new medications? _____

If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

****

Has there been any changes in your health since your last dental appointment? _____

For what conditions? _____

Are you taking any new medications? _____

If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Canton Heights Dental
Dr. William B. Klausmeyer, DDS, PC

Notice of Privacy Practices

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Consent:
By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, insurance claims, payment activities and healthcare operations.

All e-mail appointment confirmations are done through email and are non-encrypted. Any information shared with other medical/dental professionals will continue to be encrypted to maintain your privacy.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you if you revoke this Consent.

Print Name:
I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ Date _____
You are entitled to a Copy of this Consent after you sign it.

Canton Heights Dental
Dr. William B. Klausmeyer, DDS, PC

FINANCIAL POLICIES

By signing below, I acknowledge my responsibility to pay for the services received from Dr. William B. Klausmeyer, DDS, PC/ Canton Heights Dental in accordance with the office fees and terms. My responsibility is not modified by whether any third party (insurance) pays for all or part of the charges.

PAYMENT OPTIONS

PATIENTS WITHOUT DENTAL BENEFITS
Full payment is due at the time service is rendered.

PATIENTS WITH DENTAL BENEFITS
Patient pays estimated percentage of fee not covered by your dental benefits at the time of service. As thisAny overpayment by your dental benefits will be refunded to you. Any remaining balance after your insurance pays, will be your responsibility.

After 90 days any outstanding balance that has not been paid by insurance must be paid in full. If and when your dental benefits pay, we will gladly reimburse you. If not paid, there will be a 1.5% late charge added to your account and in the event of default to pay, reasonable collection charges and/or attorney fees.

CANCELLATION POLICY

We understand that a situation may arise that could force you to postpone your visit. Please understand that such changes affect not only the doctor, but other patients as well. We require 24 hours' notice for any schedule changes. There will be a $75.00 charge per hour of scheduled time for missed appointments and those cancelled with less than 24 hours' notice.

Thank you for your assistance in our commitment to excellence.

Please keep us informed of any changes in your address or dental benefits. We value every one of our patients and look forward to caring for your dental needs.

Patient/Parent Signature _____

List all family members _____
_____
_____
_____