WELCOME TO KRAUSE COMPREHENSIVE DENTAL CARE

Date _____

Patient Name _____ Preferred Name _____
First MI Last

Birthdate _____/_____/_____ Sex: ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Other

Who is the person completing this form? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Communication Preference(s)?: ☐ Text ☐ Email ☐ US Mail ☐ All of the Above

State ID/Driver's License # _____ SS# _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about our office? (If by referral, please list name) _____

BILLING INFORMATION

Who will be financially responsible for your treatment? ☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Name _____ Birthdate ____/____/____ Cell Phone _____
First MI Last

Address _____ City _____ State _____ Zip _____

StateID/Driver's License # _____ SS# _____

PRIMARY INSURANCE Insurance Type: ☐ Dental ☐ Medical

Insurance Co. Name_____

Employer _____

Bus. Address _____
Address City State Zip

Group # _____ ID# _____

Subscriber? ☐ Yes ☐ No (If Yes, skip the following)

Subscriber Name _____

Subscriber DOB ____/____/____ Relationship to Subscriber _____

Subscr. Address _____
Address City State Zip

SECONDARY INSURANCE Insurance Type: ☐ Dental ☐ Medical

Insurance Co. Name_____

Employer _____

Bus. Address _____
Address City State Zip

Group # _____ ID# _____

Subscriber? ☐ Yes ☐ No (If Yes, skip the following)

Subscriber Name _____

Subscriber DOB ____/____/____ Relationship to Subscriber _____

Subscr. Address _____
Address City State Zip

PATIENT HEALTH HISTORY

Do you have a history of: *(Please Check Yes or No)*

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive			Chest Pain			Hepatitis/Liver Disease Type(s)_____			Psychiatric Care		
Alcoholism			Convulsions/Seizures/ Epilepsy			High Blood Pressure			Respiratory/ Pulmonary Problems		
Allergies			Depression			Immune Disorder			Rheumatic Fever/Heart Disease		
Anemia			Diabetes			Kidney Disease			Rheumatoid Arthritis		
Anxiety			Drug Use			Latex Sensitivity			Sexually Transmitted Disease		
Arthritis			Excessive Bleeding			Lupus			Shortness of Breath		
Artificial or Prosthetic Joint Replacement			Excessive Thirst/Urination			Low Blood Pressure			Sinus Problems		
Artificial/Prosthetic Heart Valve			Fainting Spells			Malignancies			Stomach Ulcers		
Asthma			Hay fever			Mitral Valve Prolapse			Stroke		
Blood Disease			Head Injuries			Neck & Back Problems			Thyroid Disease		
Bone Disease			Hearing Impaired			Nervous Problems or Disorders			Tuberculosis		
Cancer			Cardiovascular Disease			Organ Transplant			Tumors or Growths		
Chemotherapy/ Radiation Treatment			Heart Valve Disease/ Murmur			Pacemaker					

MEDICATIONS

List any medications you are taking including nonprescription drugs:

_____

_____

_____

_____

Are you ALLERGIC to any medications? ☐ Yes ☐ No If yes, please list:

_____

_____

_____

_____

PHARMACY Name, Location, & Tel. No.: _____

Do you require premedication prior to dental treatment that you are aware of? ☐ Yes ☐ No If yes, please explain: _____

Do you have any other disease/problem you think we should know about? ☐ Yes ☐ No If yes, please explain: _____

_____

Are you in good health? ☐ Yes ☐ No Date of last medical exam _____

Are you now under the care of a physician? ☐ Yes ☐ No If yes, please provide name and tel. no. _____

Have you ever been hospitalized? ☐ Yes ☐ No If yes, when/why? _____

Have you undergone any surgeries? ☐ Yes ☐ No If yes, when/why? _____

Are you taking or have you ever taken any medications for cancer, osteoporosis, osteopenia, Paget's Disease, or multiple myeloma (including, but not limited to bisphosphonates e.g. Fosamax, Boniva, Actonel, Zometa, Reclast, or Prolia)? ☐ Yes ☐ No If yes, please list medication(s) and dates/durations:

_____

Do you smoke or use tobacco products? ☐ Yes ☐ No If yes, how many packs/day and for how long? _____

WOMEN ONLY:

Are you taking birth control pills? ☐ Yes ☐ No Are you nursing/breastfeeding? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Expected Delivery Date:_____ Is there a possibility of pregnancy? ☐ Yes ☐ No

DENTAL HISTORY INFORMATION

Date of last dental visit _____

Name of previous dentist _____

Reason for today's visit _____

How often do you floss your teeth? _____

Do your gums bleed when you brush? ☐ Yes ☐ No

Have you ever been treated for periodontal disease? ☐ Yes ☐ No

Does your jaw click or pop while chewing/yawning? ☐ Yes ☐ No

Are you prone to frequent headaches? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you snore or suffer from sleep apnea? ☐Yes ☐ No

Do you have problems with bad breath? ☐Yes ☐ No

Have you ever had an oral cancer screening: ☐Yes ☐ No

Have you ever used an electric toothbrush? ☐Yes ☐ No

Are your teeth sensitive to hot, cold or pressure? ☐Yes ☐ No

Have you had complications from previous dental treatment? ☐Yes ☐ No

If yes, please explain:_____

_____

Have you ever had orthodontic treatment? ☐Yes ☐ No

On a scale from 1 to 10, with 10 being the highest, how would you rate your smile? 1 2 3 4 5 6 7 8 9 10

If you could change something about your smile, what would it be? _____

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors and/or omissions that I have made in the completion of this form.

I further authorize the dentist or designated staff to take x-rays, study models, photographs, and/or employ other diagnostic aids deemed appropriate by the dentist to facilitate a diagnosis. Upon diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me, which may include the use of anesthetics, sedatives and other medications.

_____

Patient Name(s)

_____ **Date** _____

Signature of Patient *(Parent or Guardian, if Minor)*

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me and acknowledge all disclosures relative to my treatment by Krause Comprehensive Dental Care.

_____

Patient Name(s)

_____ **Date** _____

Signature of Patient *(Parent or Guardian, if Minor)*

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased 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 responsibility.

PAYMENT

Payment is due in full at the time services are rendered, unless prior financial arrangements have been made. For convenience, we accept payment in the form of cash, checks, credit and debit cards.

REGARDING INSURANCE

We file insurance claims as a courtesy to our patients and our office is dedicated to helping our patients maximize their benefits. Upon verification of coverage, we will complete your claim form so that you can be reimbursed by your insurance company to the extent of your coverage. Some carriers pay a fixed allowance for a procedure, while others pay a percentage of the fees charged**. It is your responsibility to pay deductibles, co-payments and any balance not paid by the insurance carrier**. Insurance is a contract between you and your insurance company. We are not a party to this contract in most cases; therefore, you are solely responsible for your benefits and eligibility information. (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists.) We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are ultimately responsible for the timely payment of your account.

Please note that any insurance payment estimates provided as part of your treatment plan are solely estimates generated by our practice management software. These are **NOT** guarantees of payment. For more accurate information on insurance payment towards any specific treatment, you may inquire directly with your insurance carrier or request the processing for a pre-determination of benefits. Please understand that most insurance carriers will also not guarantee benefits presented in a pre-determination, and this process can often delay treatment for several weeks. If your insurance company has not paid the FULL BALANCE within 45 days, you have 15 days to pay the balance. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

DELINQUENT ACCOUNTS

Late Payment Charges (1.5% per month) are added to unpaid accounts after 60 days from date of service. There will also be a $40 fee for any returned check. In the case of default of your account you will pay collection costs, interest on the unpaid balance until paid in full, and attorney fees incurred in attempting to collect on your present and future account balance. Collection accounts may be reported to credit service bureaus, when appropriate.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. All major treatment appointments will require a 10% deposit at time of scheduling, which will either apply toward the procedure fee(s) or be forfeited for a cancellation with less than 48 hours of notice. Please help us serve you better by keeping your scheduled appointments.

By signature below, I accept the terms of this Financial Policy and I authorize release of any information relating to a claim, to all of my insurance companies, as warranted. I further authorize payment on a claim directly to the doctor for benefits otherwise payable to me, unless alternate arrangements have been previously made. My signature also applies to all dependents listed on my account.

_____

Patient Name(s)

_____ **Date** _____

Signature of Patient/Responsible Party

Your Information. Your Rights. Our Responsibilities

This notice describes how medical information about you may be used and disclosed and

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosure

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.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- 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.

Ask us to correct your medical record

- 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.

Get a list of those with whom we've shared 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.

Get a copy of this privacy notice

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.

File a complaint if you feel your rights are violated

- You can complain 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.

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

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

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.

Example: *A doctor treating you for an injury asks another doctor overall health condition.*

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: *We use health information about you to manage your treatment and services.*

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: *We give information about you to your health insurance plan so it will pay for your services.*

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. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

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.

Note: We do not create or manage a hospital directory, nor do we provide mental healthcare or maintain psychotherapy notes at this practice.

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.

For more information see: *www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.*

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 website. *Effective Date of Notice of Privacy Practices: March 26, 2013.* This Notice of Privacy Practices applies to the following organization: *Krause Comprehensive Dental Care.*

Privacy Official and Contact Information: Diane Krause, Office Manager Tel: 973-334-5556 Fax: 973-331-0134 Email: office@kcdcmontville.com