Welcome to Klemp Family Dentistry. We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

PATIENT INFORMATION

Today's Date _____, 20_____

Patient Name _____ Date of Birth ___/___/___ Age _____

Preferred Name _____

SSN _____ Driver's Lic. # _____ DL State _____

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widowed Spouse's Name _____ DOB ___/___/___

Responsible Party: ❍ Self ❍ Other If other, who? _____

Mailing Address _____ City _____ State_____ Zip _____

Home Address _____ City _____ State_____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Are you interested in receiving text message about your appointments? ❍Yes ❍No

Would you like to receive appointment reminder by email? ❍Yes ❍No

Emergency contact person _____ Relationship _____

Cell _____ Work _____ Home _____

Preferred pharmacy name and town _____

Whom can we thank for telling you about our office? _____

EMPLOYMENT STATUS

Employer_____ Occupation_____ How Long _____ Phone_____

Spouse's Employer_____ Occupation_____ How Long _____ Phone_____

PRIMARY INSURANCE INFORMATION

Insured's Name _____ SSN/ID# _____

Insured's DOB ___/___/___ Your relationship to insured: ❍ Self ❍ Spouse ❍ Child ❍ Other _____

Insurance Company_____ Employer_____

Insurance Company Address_____ City_____ State_____ Zip _____

Group No. _____

SECONDARY INSURANCE INFORMATION

Insured's Name _____ SSN / ID# _____

Insured's DOB ___/___/___ Your relationship to insured: ❍ Self ❍ Spouse ❍ Child ❍ Other _____

Insurance Company _____ Employer_____

Insurance Company Address _____ City_____ State_____ Zip _____

Group No. _____

Financial Policy

Klemp Family Dentistry is committed to providing you with the highest quality dental care. Our financial policy is intended to help us facilitate excellent service for you.

- Payment Due: Payment is due at the time of service.

- Payment Options Include: Cash, Check, American Express, Visa, MasterCard, Discover, Care Credit
  *Care Credit is a third party agency. They offer low, and in some cases zero-interest credit card, which provides a flexible payment plan and can also be used for a variety of other health care services. More information is available at www.carecredit.com.

- Billing Insurance: As a courtesy to our patients we gladly bill your insurance.

- Insurance Coverage and Portions Due: Based on the information your insurance company provides us, we will do our best to provide you an estimate of your co-pay prior to your appointment. However, it is important to understand that your insurance coverage is an agreement between you and your insurance company. We recommend that you review and understand your policy and coverage. Many insurance companies will only pay certain portions of a charge, cover services at a percentage and some will not cover visits at all, it is your responsibility to understand all waiting periods, frequency limitations, age limits, any exceptions and exclusions of your plan. If you are "double covered" with two insurance companies, be aware of a "duplication clause" and verify whether or not your secondary insurance has standard coordination of benefits or not. It's your responsibility to provide information requested by insurance in a timely manner. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. Any claims that are over 90 days aging with insurance are your responsibility.

- Missed Appointment Fee: At Klemp Family Dentistry we value and respect your time and we ask that you will show the same respect to our office. Our office does have a cancellation policy that requires at least a 48 hour notice for cancellations or you will be charge for your missed appointment based upon the appointment. This fee must be paid before treatment can continue. If this fee is not paid or you miss three appointment or more, we reserve the right to terminate our relationship with you.

- Collections: Any balance over 90 days may be subject to additional fees, including but not limited to interest charges of 1.5% per month, or 18% annually, a $2.00 rebilling fee or collection fees for accounts that require being forwarded out of our office and being assigned to a Collection Agency.

- Other fees: Returned checks for insufficient funds or closed accounts are subject to a $25.00 fee. If a check is returned, cash, Visa, MasterCard, Discover, or Care Credit will be the only accepted forms of payment.

I have read and understand the above financial policy of Klemp Family Dentistry. I acknowledge that I am financially responsible for all charges whether or not they are covered by my insurance or any other fees applied to my account, to include but no limited to missed appointment fees, interest, and collection fees. I hereby authorize Klemp Family Dentistry to bill my insurance, to release any records or information to my insurance in order to process my claims and to be paid directly from my insurance. I also understand that where appropriate, credit bureau reports may be obtained. I agree to pay my bills in a timely manner and understand that if I do not hold up my end of this agreement, my account will be forwarded to Collections and I will be held responsible for my balance on my account as well as collection fees and/or all costs and expenses including legal and attorney fees.

Name of Patient (Please Print): _____

Signature of Patient, Parent/Guardian: _____ Date: _____

Patient Name: _____ DOB ___/___/___ Today's Date: _____, 20____

MEDICAL HISTORY

Are you allergic to any of the following?

Aspirin	☐Yes ☐No	Penicillin	☐Yes ☐No	Codeine	☐Yes ☐No	Acrylic	☐Yes ☐No
Metal	☐Yes ☐No	Latex	☐Yes ☐No	Sulfa Drugs	☐Yes ☐No	Local Anesthetics	☐Yes ☐No

Other

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No
Alzheimer's Disease	☐Yes ☐No	Excessive Thirst	☐Yes ☐No	Lung Disease	☐Yes ☐No
Anaphylaxis	☐Yes ☐No	Fainting Spells/Dizziness	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No
Anemia	☐Yes ☐No	Frequent Cough	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Angina	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No
Arthritis/Gout	☐Yes ☐No	Frequent Headaches	☐Yes ☐No	Parathyroid Disease	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Genital Herpes	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Glaucoma	☐Yes ☐No	Radiation Treatments	☐Yes ☐No
Asthma	☐Yes ☐No	Hay Fever	☐Yes ☐No	Recent Weight Loss	☐Yes ☐No
Blood Disease	☐Yes ☐No	Heart Attack/Failure	☐Yes ☐No	Renal Dialysis	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Breathing Problem	☐Yes ☐No	Heart Pacemaker	☐Yes ☐No	Rheumatism	☐Yes ☐No
Bruise Easily	☐Yes ☐No	Heart Trouble/Disease	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Cancer	☐Yes ☐No	HemophiliA	☐Yes ☐No	Shingles	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Hepatitis A	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Chest Pains	☐Yes ☐No	Hepatitis B or C	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Cold Sores/Fever Blisters	☐Yes ☐No	Herpes	☐Yes ☐No	Spina Bifida	☐Yes ☐No
Congenital Heart Disorder	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Stomach/Intestinal Disease	☐Yes ☐No
Convulsions	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Stroke	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Hives or Rash	☐Yes ☐No	Swelling of Limbs	☐Yes ☐No
Diabetes	☐Yes ☐No	Hypoglycemia	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Drug Addiction	☐Yes ☐No	Irregular Heartbeat	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Easily Winded	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tumors or Growths	☐Yes ☐No
Emphysema	☐Yes ☐No	Leukemia	☐Yes ☐No	Ulcers	☐Yes ☐No
Epilepsy or Seizures	☐Yes ☐No	Liver Disease	☐Yes ☐No	Venereal Disease	☐Yes ☐No
				Yellow Jaundice	☐Yes ☐No

Have you ever had any serious illness not listed above? ☐Yes ☐No

If yes, _____

Patient Name: _____ DOB ___/___/___ Today's Date: _____, 20___

MEDICAL HISTORY

Do you snore? ☐ Yes ☐ No

Are you under a physician's care now? ☐ Yes ☐ No

If yes, who is your primary care physician?	
Last visit?	Reason?

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes	

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

If yes	

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No

If yes	

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

If yes	

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

If yes	

Are you on a special diet? ☐ Yes ☐ No

If yes	

Do you use tobacco? ☐ Yes ☐ No

If yes type?	How Long?

Do you use controlled substances? ☐ Yes ☐ No

If yes type?	How Long?

Using the Epworth Sleepiness Scale of 0–3, how likely are you to doze off or fall asleep in the following situations?

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

_____ Sitting and reading
_____ Watching TV
_____ Sitting inactive in a public place, i.e. a theater or a meeting
_____ As a passenger in a car for an hour without a break
_____ Sitting down and talking to someone
_____ Sitting quietly after lunch without alcohol
_____ In a car, while stopped for a few minutes in traffic
_____ TOTAL SCORE

WOMEN: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No
Taking oral contraceptives? ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No

Patient Name: _____ DOB ___/___/___ Today's Date: _____, 20___

DENTAL HEALTH HISTORY

Please check Yes or No and/or what applies to you:

OYes ONo Sensitivity to: OHot OCold OSweets OPressure
OYes ONo Chipped/Broken Teeth
OYes ONo Crooked or Tipped Teeth
OYes ONo Loose Teeth
OYes ONo Missing or Spaces Between Teeth
OYes ONo Dry Mouth or Constantly Thirsty
OYes ONo Smoke or Use Chewing Tobacco
OYes ONo Uncomfortable/Uneven When I bite my Teeth Together
OYes ONo Bleeding, Swollen or Irritated Gums
OYes ONo Dissatisfied with Appearance of My Teeth
OYes ONo Frequent Headaches
OYes ONo Grinding or Clenching Teeth
OYes ONo Does food get caught between your teeth
OYes ONo Clicking or Popping of the Jaw
OYes ONo Difficulty Opening or Chewing

Please check Yes or No if you have, or have had any of the following:

OYes ONo Dentures or partials
OYes ONo Braces or clear braces
OYes ONo Periodontal disease or deep cleanings
OYes ONo Fixed Bridge
OYes ONo Dental Implants
OYes ONo Crowns
OYes ONo Do you still have your wisdom teeth
OYes ONo Whitened your teeth
OYes ONo Veneers
OYes ONo Jaw Surgery
OYes ONo Root Canals
OYes ONo Sleep Apnea
OYes ONo C-PAP Machine or Oral Sleep Appliance
OYes ONo Fear or Anxiety about Dental Treatment
OYes ONo Do you need to premedicate with antibiotic prior to your visit
OYes ONo Have you ever been sedated for Dental Treatment

How often do you brush your teeth? _____ Do you use an electric toothbrush? OYes ONo

How often do you floss your teeth? _____

Do you use anything in addition to brushing and flossing? OYes ONo If yes, what?

If I could change my smile, I would: (check those that apply)

O Make My Teeth Whiter
O Make my Teeth Straighter
O Close Spaces or Gaps That Bother Me
O Fix My Teeth So I'm Not Embarrassed When I Smile
O Repair Chipped Teeth
O Have a Smile Makeover
O Replace Old Crowns That Look Dark or Don't Match
O Replace Missing Teeth
O Replace Dark Metal Fillings With Tooth Colored Fillings

On a scale of 1–10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

If this is your first time in our office please answer the following:

When was your last dental visit: _____ Date of last complete x-ray? _____ Are you interested in sedation? OYes ONo

Who was your previous dentist: _____

Why did you leave your previous dentist? _____

What is the most important thing to you about your dental visit today? _____

I certify that the information recorded on this medical and dental form is correct. I understand it is my responsibility to notify Klemp Family Dentistry of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, andor supplements, it can be dangerous. I understand that my information will be held in the strictest confidence and only to be used to improve communication between the dentist and myself. I also give permission to Dr. Klemp to use any photos he may take to be used for lecturing and/or educational purposes.

Signature (Patient/Guardian) _____ Date _____, 20___

Klemp Family Dentistry

Astoria, Oregon 97103

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Klemp Family Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Klemp Family Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: _____	☐ **YES**	☐ **NO**
Name of patient (please print): _____		
Patient signature (if 18 years old or older): _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement of Privacy Practices**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	