Midtown Dental Clinic

Patient Information Form

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Name_____ Birthdate_____
Address_____ City_____ State_____ Zip_____
Cell #_____ Home #_____ SS #_____
Email_____ Driver's License #_____
☐ Male ☐ Female Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If college student, Name of school_____ City_____ State_____
Employer _____ Occupation_____
Address_____ Work #_____ Ext_____
Spouse or parent's name_____ Employer_____ SS #_____
Whom may we thank for referring you? _____
Emergency Contact (not living with you) _____
Relationship_____ Phone #_____
Name & Address of previous Dentist_____
Preferred Method of Contact: (check all that apply) ☐ Cell Phone ☐ Email ☐ Text ☐ Other_____

Responsible Party - Check here if same as above ☐

Person responsible for the account_____ Relationship to patient_____
Address_____ City_____ State_____ Zip_____
Phone #_____ Cell #_____ SS#_____
Driver's License #_____ Birthdate_____
E-mail Address_____
Employer _____ Occupation_____
Address_____ Work #_____ Ext_____
Is this person currently a patient in our office ☐ Yes ☐ No

Primary Insurance Information

Name of Insured_____ Phone #_____ Relationship to patient_____
Address of Insured_____ City_____ State_____ Zip_____
Birthdate_____ SS #_____ Date Employed_____
Employer_____ Union or local #_____ Work #_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Tel. #_____
Group #_____ Policy or Subscriber ID#_____

Do you have any secondary insurance ☐ Yes ☐ No if yes, complete the following:

Name of Insured_____ Phone #_____ Relationship to patient_____
Address of Insured_____ City_____ State_____ Zip_____
Birthdate_____ SS #_____ Date Employed_____
Employer_____ Union or local #_____ Work #_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Tel. #_____
Group #_____ Policy or Subscriber ID#_____

Signature_____ **Today's Date** _____
Signature of Patient or Parent, if minor

Time 10:02 AM

Midtown Dental Clinic

Eaglesoft Medical History

Date 1/12/2018

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now? ○ Yes ○ No If yes

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

Do you use tobacco? ○ Yes ○ No

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? ○ Yes ○ No If yes

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Midtown Dental Clinic

Dr. Chris Kleist, DDS & Dr. Kristina Bunch, DDS

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be Involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name: _____

Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

I **object** to disclosure of my PHI to the following person(s), but I understand you will use your professional judgment:

Their Name _____ **Your signature** _____

Their Name _____ **Your signature** _____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ○ The patient refused to sign
- ○ Communication barriers
- ○ Emergency situation
- ○ Other

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Midtown Dental Clinic

Dr. Chris Kleist, DDS & Dr. Kristina Bunch, DDS

Financial and Office Policy Information for Our Valued Patients

Again, welcome to our family. Our goal in this office is to provide the very highest quality dental treatment available at a fair value. Many of you have a dental insurance policy that will help supplement the cost of your needed dental treatment. We will do everything we can to maximize your benefits. Unfortunately, the insurance industry is changing so dramatically, that it is very difficult to keep up with the changes and how to maximize your benefits. Insurance companies make money by paying only for the very cheapest alternative, **disregarding what is in your best interest, the patient!** Very frequently, they will disregard what we diagnose utilizing x-rays and a thorough clinical exam just to decrease the benefit for you and increase the profit for them. This is where we feel we must draw the line. **We refuse to compromise in any way the quality of care our patients deserve and receive in our office, and will continue to provide the state-of-the-art dental care we would want for ourselves.** Remember we are here for you and take it very seriously when we are asked to compromise treatment just so the insurance company can make more money.

With this in mind, **we will ask that you pay for your portion of treatment at the time it is rendered.** For treatment which takes two or more visits (crowns, bridges, dentures, etc.) ½ of the balance at the first appointment and the remaining balance at the final appointment. For your convenience, we offer the following methods of payment.
□Cash* □Personal Check* □Credit/Debit Card* (Visa/MC, Discover, American Express) □Electronic Pay**
□Care Credit** * A 5% discount is given for patients without insurance that pay in full at the time of service with cash or check only.

**You may sign an authorization for us to automatically bill your credit card or checking account for balance remaining after insurance pays. Please request a form. Financial arrangements must be made and authorization form completed prior to services rendered. All returned checks will have an automatic $30.00 service charge.

All price quotes and estimates are valid for six months.

Any balance remaining after 60 days will accrue a finance charge at 1% per month (12% annual percentage rate, $1.00 minimum) as allowed by law. Delinquent accounts will be sent to Quick Collect, Inc. after 60 days.

We respect our patient's time very much, so in return we ask that you respect our time and give us at least 24 hour notice, if you cannot make it to your appointment or a fee starting at $50 may be added to your account at our discretion.

Statement of Financial Responsibility – Please Read Carefully

In order to prevent a misunderstanding about our fees and your dental insurance, we wish our patients to know that: 1. **YOUR INSURANCE COMPANY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. THEREFORE, YOU ARE LIABLE FOR THE BILL, NOT YOUR INSURANCE COMPANY**. 2. In many cases your insurance will pay only part of our fees. Since our relationship is with YOU, our bill is your personal responsibility.

I understand that I will be given an estimate of treatment and that I am responsible for the total fees, regardless of insurance coverage. I understand that decay can be more or less extensive than is revealed on a radiograph and that there could be slight changes in this estimate. I further understand that there may be contract limitations that will prevail over this estimate of insurance coverage. I am aware that Dr. Bunch and Dr. Kleist submit my insurance for payment as a complimentary service to me and that this is an estimate based on information given to them by my insurance company over the phone. If I want any additional information, I understand I must call my insurance company to obtain it. If it is necessary to employ an attorney or collection agency to collect balances due for services rendered by Dr. Bunch or Dr. Kleist and their staff, I agree to pay in addition to the principal amount then owing, interest at 1% per month (12% annual percentage rate) as allowed by law, all other lawful charges, costs and expenses of collection, including reasonable attorney's fees. If in the event suit or legal action becomes necessary, venue shall be in Benton County.

We want to thank you for your cooperation and your continued support.

Authorized Signature Patient Name Date

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