PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name _____ (Last) _____ (First) _____ (MI) _____ (Preferred)

Birthdate _____ SS# _____ Gender: ❑ M ❑ F Married: ❑ Yes ❑ No

Work Phone _____ Wireless Phone _____ Wireless Carrier _____

Email _____

Preferred contact method ❑ HmPhone ❑ WkPhone ❑ WirelessPh ❑ Email ❑ Text

Preferred contact method for confirmations ❑ HmPhone ❑ WkPhone ❑ WirelessPh ❑ Email ❑ Text

Preferred contact method for recall ❑ HmPhone ❑ WkPhone ❑ WirelessPh ❑ Email ❑ Text

Student status if dependent over 19 (for ins) ❑ Nonstudent ❑ Fulltime ❑ Parttime

How did you hear about us? _____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Address _____

Address 2 _____

City _____ State _____ Zip _____

Home Phone _____ Check box if same for entire family ❑

INSURANCE POLICY 1

Relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Subscriber Name _____

Subscriber ID # _____

Insurance Company _____

Phone _____

Employer _____

Group Name _____ Group # _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Subscriber Name _____

Subscriber ID # _____

Insurance Company _____

Phone _____

Employer _____

Group Name _____ Group # _____

Please present insurance card to receptionist.

DENTAL QUESTIONS

❑ Yes ❑ No Is everything comfortable in your mouth? If not, please explain _____

❑ Yes ❑ No Do you feel you have a healthy mouth? If not, please explain _____

❑ Yes ❑ No Are you happy with the appearance of your teeth? If not, please explain _____

❑ Yes ❑ No Are you able to eat, speak, swallow and function properly? If not, please explain _____

FINANCIAL AGREEMENT

- For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- I understand that if I begin treatment that involves lab work, I will be responsible for the fee at that time.
- If sent to collections, I agree to pay all related fees and court costs.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- Treatment plans may change, and I will be responsible for the work actually done.

Signature _____ Date _____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature _____ Date _____

MEDICAL HISTORY

Name of Medical Doctor _____ City/State _____

Emergency Contact _____ Phone _____ Relationship _____

List all the medications or drugs you are now taking:

☐ None _____

_____

_____

_____

List all the medications or drugs you are allergic to:

☐ None _____

_____

_____

_____

List any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever or of taking fen-phen.

☐ None _____

☐ Yes ☐ No Tobacco use? If so, what kind and how much? _____

☐ Yes ☐ No Do you have an unusual reaction to dental injections? If so, what happens? _____

☐ Yes ☐ No Do you have a latex allergy? If so, what happens? _____

Reason for today's visit _____

NEW PATIENTS:

☐ Yes ☐ No Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 3 years old?

☐ Yes ☐ No Do you have BiteWing x-rays that are less than 1 year old?

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____ Signature _____ Date _____

Dr. Mark Kleive, DDS
Compound Authorization for Release of Information

Patient Name:_____ **Date of Birth:**_____

Dr. Kleive's office is authorized to release protected information about the above named patient to the entities indicated below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Appointment Information: (check all that apply)

__Office may send appointment information by text
__Office may send appointment information by email
__Office may send appointment information by postcard
__Office may leave appointment information on home answering machine
__Office may leave appointment information on cell phones listed:
_____
__Office may leave appointment information only with:
_____ (names)

Financial Information:

Office may discuss billing/financial information with:_____
_____

Medical/Dental Information:

Office may discuss Medical/Dental information with:_____
_____

Insurance Filing:

Office may disclose my personal information to insurance for the purposes of filing claims on my behalf for services rendered at Mark Kleive, DDS, PA.

_____ (signature of patient or personal representative) Date:_____

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Mark Kleive, DDS, PA or to the Privacy Officer. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

_____ Date:_____
(signature of Patient or Personal Representative)

Description of Personal Representative's Authority: (i.e. parent, Power of Attorney)

_____

Our Commitments to You

A commitment between two people builds trust. I have important commitments in my practice. I have put them in writing because I live by them, as does my team. I realize that the institution of these commitments may be different from what you may have been accustomed to in other practices; however, I believe that these commitments are necessary in building the trust that it takes for you and I to successfully work together.

Commitment to Appointment:

I will reserve time especially for you in my schedule. I will give you my utmost attention and care and will rarely keep you waiting. An appointment scheduled in my office is a bond of trust that my team and I will be here to serve you and that you will be here on time and prepared for your appointment. **In order to ensure that your appointment time will remain reserved, please call, text, or email confirmation in advance of each appointment.**

Commitment to Financial Considerations:

I believe that I have a responsibility to use my best professional care, skill, and judgment in helping you achieve your dental health goals. I believe dental disease is largely preventable. I will deliver the best dental care that I am capable of delivering to help you attain your goals. It is up to you to make financial arrangements to pay for these services.

Commitment to Treatment:

I will deliver the best dental care that I am capable of delivering to you and I ask that you care for your dental health on a daily basis to the best of your ability. Incomplete treatment leads to unnecessary problems and complication, such as the loss of teeth. It also leads to more advanced disease which unnecessarily adds to your cost and can lead to a breakdown in communication between the two of us. I understand that you likely want as little dentistry as done in your life as possible. Help yourself achieve that goal by following through with your dental plan.