

WELCOME

PERSONAL INFORMATION

Date _____

Kling Orthodontics, Inc. Page 1

Name _____ I prefer to be called _____

Birthdate _____ Social Security# _____

Email address _____

Single _____ Married _____ Divorced _____ Widowed _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Email Address _____

Spouse's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Name of nearest relative not living with you _____ Relationship _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

DENTAL HISTORY

Patient's Dentist _____ Phone _____ Date of Last Visit _____

Y N Do you require antibiotic therapy before dental treatment due to a heart condition?

Y N Have you ever had any accidents that require dental care?

Y N Have you ever had any pain or tenderness in your jaw joint (TMJ / TMD)?

Y N Have you ever been treated for periodontal disease?

Y N Have you ever had root canal therapy?

Y N Are you currently in pain?

What are your primary concerns? _____

Patient's Name _____

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Patient's Physician _____ Phone _____

List all medications you are currently taking _____

List any serious medical conditions (past or present) _____

List all substances that cause you allergic reactions _____

MEDICAL HISTORY

Have you ever experienced any of the following:

- | | | |
|-----------------------------|--------------------------------|------------------------|
| Y N Abnormal Bleeding | Y N Handicaps / Disabilities | Y N Mononucleosis |
| Y N ADHD / ADD | Y N Headaches | Y N Prosthetic Devices |
| Y N AIDS / HIV Positive | Y N Hearing Impairment | Y N Rheumatic Fever |
| Y N Allergies | Y N Heart Disease | Y N Scarlet Fever |
| Y N Anemia | Y N Heart Murmur | Y N Sickle Cell Anemia |
| Y N Arthritis | Y N Hemophilia | Y N Sinus Problems |
| Y N Asthma | Y N Hepatitis | Y N Skin Rashes/ Hives |
| Y N Blood Transfusions | Y N High or Low Blood Pressure | Y N Thyroid Condition |
| Y N Bone Fractures | Y N Hospitalizations | Y N Tonsillitis |
| Y N Cancer | Y N Kidney Problems | Y N Tuberculosis |
| Y N Chicken Pox | Y N Liver Problems | |
| Y N Congenital Heart Defect | Y N Lupus | |
| Y N Diabetes | Y N Major Accidents | |
| Y N Epilepsy | Y N Measles | |
| Y N Fainting Spells | Y N Mitral Valve Prolapse | |

Patient's Signature _____ Date _____ Doctor _____

Patient's Signature _____ Date _____ Doctor _____

Patient's Name _____

ORTHODONTIC INSURANCE INFORMATION

PRIMARY

Insurance Company _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Group # _____

ID# _____ Insured's Employer _____

Employer Street Address _____ City _____ State _____ Zip _____

SECONDARY

Insurance Company _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Group # _____

ID# _____ Insured's Employer _____

Employer Street Address _____ City _____ State _____ Zip _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the above named patient(s) medical status. I authorize the dental staff to perform the necessary dental services the above named patient may need.

Signature _____ Date _____

I agree to be responsible for all charges for dental services and materials not a benefit of my dental plan. I authorize the release of any information relating to the dental benefit claim, and authorize payment of the dental benefit otherwise payable to me directly to Kling Orthodontics, Inc.

Signature _____ Date _____

KLING ORTHODONTICS, INC.
INFORMATION DISCLOSURE AUTHORIZATION

PATIENT _____

Authorization for release of protected patient information is given to the following named person (s):

Name	Relationship to patient	Treatment	Financial
1. _____	_____	_____	_____

CONTACT NUMBER _____

2. _____

CONTACT NUMBER _____

3. _____

CONTACT NUMBER _____

Verification of Identity or Password _____

Signature _____

Relationship to Patient _____

Date: _____

You have the right to revoke this authorization at any time by providing and submitting written notice to Kling Orthodontics. Revocation of this authorization will not affect any information disclosed prior to receipt of your revocation.

KLING ORTHODONTICS, INC.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of this consent: By signing this form, you will give consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of privacy practices: You have the right to read our Notice of Privacy 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 the protected health information, and of other important matters about the protected health information. A copy of our notice accompanies this consent. 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 the patient's protected health information we maintain. You may obtain a copy of our Notice of Privacy Practices at any time by contacting Kling Orthodontics, Inc. at either of these office locations:

1470 S. New Florissant Road
Florissant, MO. 63031-8198
Office: 314-837-5787
Fax: 314-837-8080

11 Azusa Street
St. Peters, MO. 63376-5386
Office: 636-928-1153
Fax: 636-928-0700

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 the contact person listed above. Please understand that revocation of 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 the patient or continue treating the patient if you revoke this consent.

Patient Name: _____

Patient Address: _____

Patient Telephone: _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY GIVING CONSENT:

I, _____, have full authorization as the patient, parent, or personal representative to sign this form, and 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 form, I am giving Kling Orthodontics, Inc., my consent to use and disclosure of the patient's protected health information to carry our treatment, payment activities and health care operations. I am entitled to a copy of this consent after I sign it.

SIGNED: _____ DATE: _____

Relationship to patient: _____

KLING ORTHODONTICS, INC.

1470 S. NEW FLORISSANT ROAD
FLORISSANT, MO. 63031
314-837-5787

11 AZUSA STREET
ST. PETERS, MO. 63376
636-928-1153

**NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT**

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be used by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice.

I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

Relationship to the patient (if signed by a personal representative of patient):
