WELCOME

CHILD'S INFORMATION

Date_____ Kling Orthodontics, Inc. Page 1

Child's Name_____ Nickname _____

Male____ Female_____ Birthdate_____ Age_____ Home Phone_____

Child's Home Address_____ City_____ State____ Zip_____

School Child Attends_____ Grade_____

Whom may we thank for referring you?_____

PARENT'S / GUARDIAN'S INFORMATION

Mother_____ Step-Mother_____ Guardian_____

Name_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Email Address_____

Father_____ Step-Father_____ Guardian_____

Name_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Name of Nearest Relative (Not Living With You)_____

Street Address_____ City_____ State_____ Zip_____

Phone_____

Person Responsible for the account_____ Relationship_____

Street Address_____ City_____ State_____ Zip_____

Phone_____

DENTAL HISTORY

Patient's Name_____ Kling Orthodontics, Inc. Page 2

Patient's Dentist_____ Phone_____ Date of Last Visit_____

Yes No Does the patient require antibiotic therapy before dental treatment due to a heart condition?
Yes No Has the patient had any accidents requiring dental care?
Yes No Has the patient ever had any pain or tenderness in his/her jaw joint (TMJ / TMD)?
Yes No Has the patient ever been treated for periodontal disease?
Yes No Has the patient had root canal therapy?
Yes No Is the patient currently in pain?

Does / Did the patient have any of the following habits?

Y N Nail Biting	**Y N** Mouth Breather	**Y N** Clenching / Grinding Teeth
Y N Thumb Sucking	**Y N** Speech Problems	**Y N** Tongue Thrust

Medical History

Patient's Physician_____ Phone_____

Please list all medications that the patient is currently taking_____

Please list all substances that cause the patient allergic reactions_____

Please explain any serious medical problems (past or present)_____

Has the patient 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 / Excessive Bleeding	**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 Transfusion	**Y N High or Low Blood Pressure**	**Y N Thyroid Condition**
Y N Bone Fractures	**Y N Hospitalizations / Surgeries**	**Y N Tonsillitis**
Y N Cancer	**Y N Kidney Problems**	**Y N Tuberculosis**
Y N Chicken Pox	**Y N Liver Problems**	**Y N Ulcers**
Y N Congenital Heart Defect	**Y N Lupus**	
Y N Diabetes	**Y N Major Accidents**	
Y N Epilepsy / Seizures	**Y N Measles**	
Y N Fainting Spells	**Y N Mitral Valve Prolapse**	

Parent or Guardian Signature_____ Date_____ Doctor_____

Parent or Guardian Signature_____ Date_____ Doctor_____

Parent or Guardian Signature_____ Date_____ Doctor_____

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 heath 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):

_____