WELCOME TO

KLINGER FAMILY DENTISTRY

James P. Klinger, D.D.S.

Emma O'Heeney, D.M.D.

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

TODAY'S DATE _____

OFFICE USE ONLY

1. ABOUT YOU, THE PATIENT

Name: _____

I prefer to be called _____

Male _____ Female _____

Birthdate: _____ SS# _____

Marital Status: _____

Home

Address: _____

City _____ State _____ Zip Code _____

Home Phone # _____

Cell Phone # _____

Email Address: _____

Employer: _____

Employer's Address: _____

Phone # _____ Ext. _____

Whom may we thank for referring you:

_____

2. SPOUSE INFORMATION

Name: _____

Employer: _____

Work Phone # _____ Ext. _____

Birthdate: _____ SS# _____

3. RESPONSIBLE PARTY

Name of person responsible for account:

_____

Relationship to patient: _____

Billing Address: _____

_____

Home # _____ Work # _____

Employer: _____ SS# _____

4. DENTAL INSURANCE INFO

PRIMARY DENTAL INSURANCE

Insured's Name: _____ Relation: _____

Birthdate: _____ SS# _____

Employer: _____

Insurance Co. Name: _____

Group #: _____ Policy #: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

SECONDARY DENTAL INSURANCE

Insured's Name: _____ Relation: _____

Birthdate: _____ SS# _____

Employer: _____

Insurance Co. Name: _____

Group #: _____ Policy #: _____

5. DENTAL HISTORY

Reason for Today's Visit

_____

Are your Teeth Sensitive to:

Cold Hot Sweets Biting

Does Food Collect between Your Teeth: _____

Have you ever had excessive bleeding after a dental extraction? _____

Have you ever experienced pain or discomfort in your jaw joint (TMJ)?

_____

Have you ever had a difficult problem associated with any previous dental work?

_____

What do you like least about your teeth?

_____

Have you ever considered having your teeth whitened?

_____

Last Dental Visit Date: _____

Previous Dentist: _____

6. MEDICAL HISTORY

Name of Physician: _____ Date of last Physical Exam: _____

Are you currently under the care of a physician? _____

If so, what is the condition being treated? _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? _____

If so, for what? _____

Are you taking any prescription/over-the-counter medicines? _____ Please list each one: _____

_____

Are you allergic to any of the following: Circle those that apply:

Penicillin Tetracycline Aspirin Erythromycin Codeine Nickel Latex Dental Anesthetics

Other Antibiotics---Please list: _____

Please list any other allergies that you are aware of (foods, drugs, pollens, etc.): _____

_____

FOR WOMEN:

Are you taking birth control pills? _____ Are you pregnant? _____

_____

To your knowledge, have you ever had any of the following medical conditions: Circle those that apply.

Artificial Joints
Abnormal Bleeding
AIDS, HIV Positive, ARC
Arthritis
Diabetes
Ear or Eye Problems
Epilepsy
Blood Transfusion
Drastic Weight Change
Severe/Frequent Headaches
Abnormal Blood Pressure (High/Low)
Heart Attack
Stroke
Mitral Valve Prolapse
Rheumatic Fever
Fainting Spells, Seizures
Chemotherapy
Venereal Disease
Heart Murmur
Congenital Heart Defect
Hepatitis
Kidney, Urinary or Bladder Problems
Nervous or Mental Disorders
Respiratory Disease or Tuberculosis
Radiation Therapy
Asthma
Ulcers/Colitis
Acid Reflux

If you circled any of the above, please explain: _____

_____

If you have any disease, condition, or problem not listed above, please explain: _____

_____

I realize that my insurance company, if any, has an obligation to me and not to the dentist. This office has no contractual arrangement with insurance carriers, therefore I am responsible to this office for payment of services rendered. I authorize this dental staff to perform any necessary dental services with my informed consent that I need during diagnosis and treatment.

SIGNATURE _____ DATE _____

OFFICE USE ONLY ------- MEDICAL HISTORY UPDATE

Date:

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

Eaglesoft Medical History(Copy) 1

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 that you may be taking, c

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
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

☐ PEANUT/ TREENUT

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss/Gain ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No
Renal Dialysis ◯ Yes ◯ No	Anemia ◯ 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	Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No
Hives or Rash ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No
Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Blood Transfusion ◯ 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	Low Blood Pressure ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No
Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No
Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No	Snoring ◯ Yes ◯ No	Depression ◯ Yes ◯ No	Bruxism/Grinding Teeth ◯ Yes ◯ No
Fatigue ◯ Yes ◯ No			

Have you ever had any serious illness not listed above?	◯ 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:_____

Klinger Family Dentistry

Financial Policy

Welcome to Klinger Family Dentistry. Thank you for choosing our office as your dental healthcare provider. We are committed to providing the highest quality and affordable dental care for you and your family. The following is a statement of our financial policy.

Payment is due at the time of service. Our office accepts cash, personal checks, all major credit cards, and Care Credit. In office financing may be offered on approved cases.

All account balances over 90 days are subject to a $35 late fee. Delinquent accounts over 90 days will be handled by a collection agency. All fees incurred from the collection agency will be charged to your account. If legal action is necessary all fees incurred will be your responsibility.

A returned check fee of $40 (subject to change as bank fees change) will be added to your account for any returned check. The $40 fee plus full payment for the returned check amount must be paid in cash or by credit card.

We schedule your dental appointments carefully to reduce your waiting time and costs. Missed appointments can increase costs. We request at least 24 hours advance notice for rescheduling your appointment. We do understand that unforeseen circumstances may arise, which may result in canceling or rescheduling appointments on short notice. However, a $40 fee may be charged for multiple failed appointments without proper notification.

INSURANCE

All charges incurred are your responsibility, regardless of your insurance coverage. We must emphasize that as a dental care provider, our relationship is with you. Your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.

As a courtesy to you, we will help you process your dental insurance claims. Please understand that any insurance coverage estimate may not be exact. It is NOT a guarantee that insurance will pay exactly as estimated. Insurance coverage is subject to several limitations. It is your responsibility to be aware and understand these limitations. We will do all we can to ensure your estimate is accurate based on the information we have. Your insurance company and your plan benefits ultimately determine the amount paid. Contact your insurance company for a detail of your benefits and limitations.

The treatment recommended to you is based on your needs and not your insurance coverage. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We ask that you sign all necessary documents that may be required by your insurance company.

We ask that you pay the deductible and/or co-payment at the time the service is provided to you.

Insurance payments are ordinarily received within 30-60 days from the time of filing the claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will NOT enter into a dispute with your insurance company over any claim.

In order for our office to properly manage your dental care needs current information is imperative. Please keep your records up to date by informing us of any changes to your account. This would include but not be limited to: name, address, phone numbers, email address, employer, insurance and all medical/health history.

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THIS FINANCIAL POLICY.

Please Print Responsible Party Name (include all patients under 18 you are responsible for): _____

_____

Responsible Party Signature: _____ Date: _____

Klinger Family Dentistry

9405 Illinois Rd
Fort Wayne, In 46804

James P Klinger, DDS
Emma K O'Heeney, DMD

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ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received (or was offered but declined) a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE INFORMATION

The following people have my permission to obtain information that is protected by the HIPAA Privacy Notice:

Please print: _____

Please print: _____

Please print: _____
(for additional lines please use back of form)

_____ I do not allow anyone access to my information.

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AUTHORIZATION TO RELEASE/OBTAIN X-RAYS

I authorize Klinger Family Dental to obtain and/or release my x-rays from/to a previous or new dental provider.

Signature: _____ Date: _____