Registration

Date _____

PATIENT NAME:		PREFERRED NAME:	
DOB	Age	Social Security #	
Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Separated		Sex ◉ M ◯ F	
Home Address	City, State, Zip	Email	
Home Phone #	Cell Phone #	Work Phone #	
Your Employer	Work Occupation		
Work Address		Referred to us by	

Are you a full time student? ◯ Yes ◯ No

If patient is a minor we need:

Mother's Name	DOB	Social Security #
Father's Name	DOB	Social Security #
Person responsible for the account		
EMERGENCY INFORMATION Name, Address & Telephone of a relative not living with you		

Dental Insurance Information (Primary Carrier)

Subscribers Name	Relationship to Patient	Subscribers DOB
Dental Insurance Company Name & Address		Phone #
Subscribers Employer	Subscribers ID	Subscribers Soc. Sec. #

Health History

Date _____

Name _____

Your Physicians Name _____ Last Medical Exam _____

Physicians Phone # _____ Are you under active medical care? ◯ Y ◯ N

Rate your general health: ◯ Poor ◯ Good ◯ Fair ◯ Excellent

Health conditions: Put a ✓ in the box for any health conditions you have now or have had in the past.

☐ Heart Condition	☐ Bruise Easily	☐ Diabetes	☐ Arthritis/Rheumatism
☐ Heart Attack	☐ Shortness of Breath	☐ Sickle Cell Disease	☐ Pain In Jaw Joints
☐ Stroke	☐ Swelling of Ankles	☐ Liver Disease	☐ Fainting/Dizzy Spells
☐ Replacement Valve	☐ Artificial Joint	☐ Hepatitis A (infectious)	☐ Alcoholism
☐ Chest Pains (Angina)	☐ Lung Disease	☐ Hepatitis B (serum)	☐ Drug Addiction
☐ Heart Surgery	☐ Emphysema	☐ Hepatitis C	☐ Cancer or Tumor
☐ Artificial Heart Valve	☐ Tuberculosis (T.B.)	☐ Blood Transfusion	☐ Radiation Therapy
☐ Heart Pacemaker	☐ Asthma/Hay Fever	☐ Thyroid Disease	☐ Chemotherapy
☐ High Blood Pressure	☐ Skin Rashes/Hives	☐ Cortisone Medicine	☐ HIV Positive/AIDS
☐ Rheumatic Fever	☐ Kidney Trouble	☐ Glaucoma	☐ Venereal Disease
☐ Genital Herpes	☐ Epilepsy/Seizures	☐ Latex Sensitivity	☐ Yellow Jaundice
☐ Cold Sores	☐ Psychiatric Treatment	☐ Metal Sensitivity	☐ Anemia/Hemophilia
Other:			

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Medicines and supplements: Please list any medicines you take (prescription and over the counter):

	What? How often? How much? If there are none, write "none." If you don't know, write "don't know."
Prescription medicine	
Over-the-counter medicine	

Are you allergic to any medicine, drug, or other substance? ◯ Yes ◯ No ◯ Don't know

I am Allergic to: _____

Have you had a bad reaction to local anesthetic? ◯ Yes ◯ No ◯ Don't know

Have you had prolonged or unusual bleeding or bruise easily? ◯ Yes ◯ No ◯ Don't know

Do you smoke? ◯ Yes ◯ No How much? How long?

Do you use smokeless tobacco? ◯ Yes ◯ No

Women: Are you pregnant right now? Due Date ◯ No ◯ Yes

Do you use birth control pills or implants? ◯ No ◯ Yes

Do you anticipate becoming pregnant? ◯ No ◯ Yes

Have you had any complications or problems with a previous pregnancy? ◯ No ◯ Yes

Dental History

Date _____

What are your dental concerns?

Are you having dental pain at this time? ◯ No ◯ Yes

Where? How long?

What is the name of your previous dentist?

When was your last visit? Was all dental treatment completed?

Are you afraid of dental treatment? ◯ No ◯ Yes

Have you ever been diagnosed with any form of gum disease? ◯ No ◯ Yes

What kind?

Are your teeth sensitive to hot, cold, sweet, sour? ◯ No ◯ Yes

Do you clench or grind your teeth when sleeping or awake? ◯ No ◯ Yes

Do your jaws get sore, tired, pop, catch, lock? ◯ No ◯ Yes

Put a ✓ in the box if you have had:

☐ TMJ Therapy	☐ Root Canal Treatments	☐ Wisdom Teeth Extracted
☐ Broken Jaw	☐ Partial Dentures (date:)	☐ Complete Dentures (date:)
☐ Sleep Apnea	☐ Facial Injuries	☐ Gum Surgery / Treatment
☐ Implants	☐ Crowns (caps)	☐ Fixed Bridges
☐ Whitening	☐ Braces	

I WOULD LIKE MORE INFORMATION ON:

☐ Tooth Whitening ☐ Invisalign ☐ Implants ☐ Missing Teeth Replaced ☐ Orthodontics

☐ Cosmetic Bonding ☐ Teeth Extracted ☐ Complete Dentures ☐ Smile Improvement

Other:

Smile Evaluation - How would you rate your smile on a scale of 1(*hate it*) - 10(*love it*)?

I would like a nicer smile ◯ Yes ◯ No

My teeth are too dark or stained ◯ Yes ◯ No

I want straighter teeth ◯ Yes ◯ No

I don't like the gaps between my teeth ◯ Yes ◯ No

My old dental work is unsightly ◯ Yes ◯ No

Tell me what I can do to improve my smile ◯ Yes ◯ No

What would make your smile better?

PATIENT FINANCIAL CONSENT

Payment is due at the time of service. We ask that you pay the deductible and co-payment, which is the estimated charges not covered by your insurance company by cash, personal checks, Master-card, Visa, American Express, Discover, or Care Credit.

Please note returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred, along with any charges associate with those agencies, and/or finance charges.

Insurance payments are ordinarily received within 30-60 days from the time of filing. If payment has not been received by your insurance company within 30 days, we ask that you contact your insurance company to make sure payment is expected soon. If after 60 days 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, however, enter into a dispute with your insurance company over any claim.

Insurance

I authorize the practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, and all information, records and other diagnostic materials about my medical history, services rendered, or recommended treatment.

I authorize the practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on behalf and in my name listed as "signature on file" and assign to the practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimated to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid.

- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company arbitrary determination of usual and customary rates.

I have read this patient consent and agree to all terms and conditions herein.

x _____ Date: _____

Kirchner Dental
COMPREHENSIVE DENTAL SOLUTIONS

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THE INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.
*You may refuse to sign this acknowledgment.

_____	x _____	_____
Please PRINT Patient's Name	Patient or Guardian Signature	Date

KIRCHNER DENTAL & PATIENT MUTUAL AGREEMENT

I understand I have the opportunity to ask questions and receive satisfactory and adequate explanations.

So agreed: x _____ _____

Patient or Guardian Signature — Date

We take pride in being able to extend a greater degree of privacy than is required by law. Federal and state privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, dentists are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some dental practices, though. can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Kirchner Dental, (hereinafter referred to as KD), feels this is improper and may not be in the patient's best interest. Accordingly, we agree not to provide medical/ dental information for the purpose of marketing directly to our patients. Regardless of the legal privacy loopholes, we will never attempt to leverage our relationship with you by seeking your consent for marketing products for others.

KD has invested significant financial and marketing resources in developing this practice. Nothing in this Agreement prevents a patient from posting commentary about KD on web pages, blogs and/or mass correspondence. In consideration for treatment and the above noted patient protection, if you prepare such commentary for publication about KD, you exclusively assign all intellectual Property rights, including property rights, to KD for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from KD's last date of service to you. As a matter of office policy, KD is requiring that all patients in our practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this Agreement for all KD patients. Further this Agreement will survive for a minimum for three years beyond any termination of KD - Patient relationship.

KD and patient acknowledge that breach of this Agreement may result in serious, irreparable harm. KD and patient agree to the right of' equitable relief (including but not limited to injunctive relief). Should a branch of this Agreement result in litigation, the prevailing party in litigation shall be entitled to reasonable costs, expenses and attorney fees associated with the litigation.

NOTICE OF PRIVACY PRACTICE

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This notice takes effect as of the date of signing, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information. or for additional copies of this Notice, please contact us.

USES AND DISCLOSURES OF HEAL TH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations: For example: Treatment: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your health information to obtain a payment for services we provide you. Healthcare operations: We may use and discuss your health information in connection with our healthcare operations. Healthcare operations practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Your Authorization: You may give us a written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health Information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health Information based on a determination using our professional judgment and our experience with common practice to make reasonable inferences to your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. As required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: We may use or disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and health information of inmate or patient under certain circumstances. Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, or letters).

PatientRights

Access: You have the right to view or receive copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We may charge a reasonable fee for expenses such as copies and staff time. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Disclosure Accounting: You have the right to receive a list of instances in which we, or our business associates, disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee. Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to the additional restrictions, but if we do, we will abide by our agreement, (excluding emergencies). Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request In writing. Your request must specify alternative means or locations, and provide satisfactory explanation of how payment will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on our website by electronic mail, you are entitled to receive this Notice in written form.

QuestionsandComplaints:

If you have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, please contact us in writing. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint, upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us, or with the U.S. Department of Health and Human Services.

Kirchner Dental -1706 Williamsburg Drive- Jeffersonville, IN 47130-812.283.5550