My East Cobb Dentist, PC

Erik Klein, DDS

PATIENT REGISTRATION FORM

Welcome to our practice!

Thank you for selecting our dental team. Please fill out this form completely in ink and print clearly. If you have any questions or concerns, please ask for assistance - we will be happy to help.

Date:_____

Name:_____Soc.sec.#_____BirthDate_____/_____/_____

Last ,First, Middle

Home address_____City_____State_____Zip_____

Home phone_____Work phone_____ Cell _____

E-mail address:_____

Are you: Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Student?Where?_____

Spouse or parent's name_____Employer_____Daytime Phone_____

Emergency Contact:_____Phone_____Reason for today's visit?_____

We appreciate patient's referring others to us. Who may we thank for referring you?_____

RESPONSIBLE PARTY

Name of person responsible for this account_____ Date of birth_____Relationship_____

Address_____Home Phone_____

City, State, Zip_____ Soc. Sec.#_____

Employer_____ Work Phone_____

Primary Dental Insurance Carrier:

Primary insured's name_____SS#_____Date of Birth_____

Employer_____ Group #_____

Insurance Company_____ Insurance Company Phone #_____

Insurance Company address_____Relationship to patient _____

Secondary Dental Insurance Carrier:

Primary insured's name_____SS#_____Date of Birth_____

Employer_____ Group #_____

Insurance Company_____Insurance Company Phone #_____

Insurance Company address_____Relationship to patient _____

Authorization to release medical /dental Information, Authorization of payment:

I authorize the release of any medical/dental information necessary to process my insurance claim(s). I also certify that all insurance information given to My East Cobb Dentist, PC is correct and complete.

I hearby authorize and direct payment of the dental benefits otherwise payable to me, to be paid directly to: to My East Cobb Dentist, PC . A photocopy of my signature shall be valid as original.

Patient signature_____Date_____Insured signature_____Date_____

DENTAL HISTORY Please circle

Do you have any specific dental problems_____	Yes No
Do you have dental examinations on a routine basis? Last visit_____	Yes No
Do you think you have active decay or gum disease? _____	Yes No
Do you brush and floss on a regular basis? Discuss_____	Yes No
Do your gums ever bleed? Discuss _____	Yes No
Do you like your smile? Discuss_____	Yes No
Does food catch between your teeth? Any loose teeth? _____	Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind?_____	Yes No
Do you want to keep your remaining teeth? _____	Yes No
Have your past experiences in a dental office always been positive?_____	Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss_____	Yes No

Name of previous dentist (optional):_____Date of last full mouth x-rays:_____

MEDICAL HISTORY

Are you under a physician's care now? Why? Who? _____Phone#_____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to the head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____Yes No

Are you allergic to any medications or substances? Please circle below

Aspirin Penicillin Codeine Acrylic Metal Latex rubber Other_____

Women (Please circle): Pregnant/trying to get pregnant Nursing Taking oral contraceptives

If yes to any of the starred conditions, please call prior to appointment…. Pre-medication may be required.

Yes No	Yes No	Yes No
☐ ☐ Heart Trouble/Disease	☐ ☐ Bruise Easily	☐ ☐ Emphysema
☐ ☐ Heart Murmur *	☐ ☐ Anemia	☐ ☐ Tuberculosis
☐ ☐ Irregular Heartbeat	☐ ☐ Excessive Bleeding	☐ ☐ Cancer
☐ ☐ Angina / Chest Pain	☐ ☐ Sickle Cell Disease	☐ ☐ X-Ray Treatments (Radiation)
☐ ☐ Heart Attack/ Failure	☐ ☐ Hemophilia (Bleeding problem)	☐ ☐ Chemotherapy
☐ ☐ Congenital Heart disorder	☐ ☐ Leukemia	☐ ☐ Stomach/ Intestinal Disease
☐ ☐ Mitral Valve Prolapse *	☐ ☐ Recent Blood Transfusion	☐ ☐ Ulcers
☐ ☐ Scarlet Fever *	☐ ☐ Swelling of Limbs	☐ ☐ Recent Weight Loss
☐ ☐ Rheumatic Fever *	☐ ☐ Lung Disease	☐ ☐ Frequent Diarrhea
☐ ☐ Artificial Heart Valve	☐ ☐ Breathing Problem	☐ ☐ Diabetes
☐ ☐ Heart Pace Maker	☐ ☐ Shortness of Breath	☐ ☐ Excessive Thirst
☐ ☐ Heart Surgery	☐ ☐ Frequent Cough	☐ ☐ Hypoglycemia
☐ ☐ High Blood Pressure	☐ ☐ Hay Fever	☐ ☐ Liver Disease
☐ ☐ Low Blood Pressure	☐ ☐ Sinus Trouble	☐ ☐ Hepatitis A (infectious)
☐ ☐ Blood Disease	☐ ☐ Asthma	☐ ☐ Hepatitis B or C
☐ ☐ Yellow Jaundice	☐ ☐ Cold Sores	☐ ☐ Thyroid Disease
☐ ☐ Kidney Problems	☐ ☐ Fever Blisters	☐ ☐ Parathyroid disease
☐ ☐ Renal Dialysis	☐ ☐ Herpes	☐ ☐ Arthritis/ Gout
☐ ☐ Venereal Disease	☐ ☐ Stroke	☐ ☐ Rheumatism
☐ ☐ AIDS	☐ ☐ Convulsions	☐ ☐ Pain in Jaw Joints
☐ ☐ HIV Positive	☐ ☐ Epilepsy or Seizures	☐ ☐ Cortisone Medicine
☐ ☐ Genital Herpes	☐ ☐ Fainting or Dizziness	☐ ☐ Glaucoma
☐ ☐ Drug Addiction	☐ ☐ Nervousness	☐ ☐ Tumors or Growths
☐ ☐ Allergies (Medicines)	☐ ☐ Psychiatric Care	☐ ☐ Alzheimer's Disease
☐ ☐ Allergies (Pollen or Dust)		

Have you ever had any other serious illness not checked above? Discuss_____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No
the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and the staff at the next appointment without fail.
X_____Date_____ Reviewed by Doctor_____Date_____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

FUTURE UPDATES

Are there any changes in your medical history?
Yes ☐ No ☐
If yes, what changes?
_____
Date: _____Signature: _____
Dentist's Signature _____

Are there any changes in your medical history?
Yes ☐ No ☐
If yes, what changes?
_____
Date: _____Signature: _____
Dentist's Signature _____

Are there any changes in your medical history?
Yes ☐ No ☐
If yes, what changes?
_____
Date: _____Signature: _____
Dentist's Signature _____

Are there any changes in your medical history?
Yes ☐ No ☐
If yes, what changes?
_____
Date: _____Signature: _____
Dentist's Signature _____

FINANCIAL POLICY

All Co-Pays are expected at the time services are rendered unless prior arrangements have been made. If you have any questions concerning financial arrangements or need special arrangements, please speak with the Financial Manager.

I understand that credit card refunds do not include non-refundable bank fees.
I understand that a fee of $45 dollars will be charged for all returned checks

I understand that treatment quotes are always an 'estimate'. I will be asked to pay my estimated portion at the time of service, with the understanding that if the insurance company does not pay part, or any of the claim, the balance will become my responsibility.

I understand that staff **of to My East Cobb Dentist, PC cannot guarantee how much, or even if, my insurance company will pay** on a claim, since my insurance coverage is an agreement between me and my insurer and insurance plans vary widely in their allowable fees and covered charges. I further agree to immediately sign over to to My East Cobb Dentist, PC, without cashing, any insurance payments sent to me. If I should hold these funds, I agree to pay to My East Cobb Dentist, PC a **20% late fee** for the amount of any funds I may take.

I understand that the filing of insurance claims is a service provided to me without charge. My insurance claim will be sent the same day that service is rendered. If my insurance company has not provided payment within 30 days, any unpaid balance will become my responsibility.
I understand that it is my responsibility to follow-up on outstanding insurance claims to avoid any past- due charges.

I understand that accounts which are past due will be assessed a monthly interest and billing charge. I realize that failure to keep this account current may result in to My East Cobb Dentist, PC in being unable to provide additional services except for dental emergencies or where there has been prepayment for additional services. In the case of default on payment, I agree to pay collection costs and reasonable attorneys fees incurred in attempting to collect on this or any future outstanding account balances.

I realize that a broken appointment is a loss to everyone and that by holding my appointment, I am blocking other patients from this time. I understand that I will be charged $ 45.00 for a broken appointment and that I can possibly be charged up to the actual fee if I cancel without 48 hours notice.

A photocopy of my signature shall be valid as original.

Signed_____Date_____ Financial Coordinator_____Date_____

My East Cobb Dentist, PC
770-579-6400

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, My East Cobb Dentist, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to My East Cobb Dentist's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. My East Cobb Dentist reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to My East Cobb Dentist -Privacy Officer at 4200 Providence Rd, Marietta, GA 30062.

With my consent, My East Cobb Dentist may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, My East Cobb Dentist may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, My East Cobb Dentist may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that My East Cobb Dentist restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to My East Cobb Dentist's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, My East Cobb Dentist may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Date

_____
Print Name of Patient or Legal Guardian