TIME 09:02 AM

DATE 7/24/2023

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Gender: ☐ Male ☐ Female ☐ Unknown Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Referred By _____

Previous Dentist _____

Emergency Contact _____

Emergency Contact # _____

Physician _____

Physicians Phone _____

Employer _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

KIEL & NEW HOLSTEIN
FAMILY DENTAL

We welcome you to our dental practice. We would like to share with you the policies at Kiel and New Holstein Family Dental. We are a family dental practice dedicated to providing the best treatment to all of our patients. In order to provide the best treatment to our patients we have adopted the following policies. Please do not hesitate to ask our staff any questions.

Payment Options: Our office accepts cash, check, VISA, MC, Discover, American Express, Alpheon Credit and Care Credit. We ask for any co-payments to be paid on the day of service.

Insurance Filing: As a courtesy to our patients, we will file dental claims with your insurance for charges incurred at our clinic. Please remember your insurance policy is an agreement between yourself, your employer, and your insurance company. If a service provided by our clinic is not covered in your policy, you will be responsible for the charges. We file claims to all insurances, but are not in-network providers for all policies. Today's dental plans are meant to help patients cover a portion of their dental treatment, but do not cover all necessary treatment. As providers we will give you all options for treatment without regard to insurance coverage. If possible, we will file a pre-authorization with your insurance so that you have an ESTIMATE of your co-payment responsibilities. Please understand that dentistry is not an exact science, treatment plans and recommendations may be altered during times of treatment. You are responsible for your co-payment, even if it differs from the pre-authorization estimate. We have the same policy if your insurance company pays less than is estimated on their pre-authorization. The estimated amount due may not take into account insurance deductibles or changes to your insurance plans. If your insurance changes or is lost during treatment, you will be responsible for all costs not covered by your insurance company. The details of your individual policy are your responsibility.

If there is no dental insurance, you understand that you are responsible for paying, in full, for services the day of treatment.

Collections:

Non-sufficient funds: A $35 charge will be added for any non-sufficient funds notice received from the bank

Cancellation policy: I must respect the practice's schedule and will give 24 business hours notice to reschedule or cancel an appointment. If this does not occur, you may be assessed a $50 short notice cancel fee for the loss of the appointment time.

If payments for services rendered are not paid within 120 days and alternative arrangements have not been made, accounts will be turned over to a collection agency.

I have read, agreed to, and understand the statements listed above. I can receive a copy of this document at my request.

X_____ _____

Patient's signature Today's Date

_____ _____

Patient name: Please print Date of Birth

Consent to treat minor children at our office without a parent present: please read and initial below:

_____ I give Kiel and New Holstein Family Dental permission to treat my minor child/children in my absence whether I drop them off for treatment or another adult brings them to the office for treatment. I will give my child a check or credit card information to fulfill any co-payments due for treatment that day. We will try to contact you if there are treatment changes while your child is in the dental chair, but you understand that it may not be possible to advise you of changes if we cannot get ahold of you.

For parents who have an adult child (over 18) and will continue to be financially responsible for their treatment. Please complete below:

_____ I will continue to be financially responsible for _____ (child's name). If I have insurance, I will provide my insurance company with the necessary documentation to continue their coverage.

HIPAA Consent

The patient understands that:

- Reminders of upcoming scheduled appointments may be left on answering machines, voicemail, emails, or texting with a family member
- We can send radiographs with minimal amount of information necessary via email on your behalf when referring you to another provider
- We can fax or call in prescriptions to the pharmacy on your behalf
- Protected health information may be disclosed or used for treatment, payment or dental care options
- Kiel Family Dental has a "Notice of Privacy Practices" available at the front desk for your review, available at any time
- The patient may revoke this consent in writing at any time

Acknowledgment of Receipt of Notice Of Privacy Practices

By signing below, you are acknowledging that you have received a copy of Kiel Family Dental's Notice of Privacy Practices

Patient Name: _____

Patient Representative: _____

If signed by a Patient Representative, state authority to act on behalf of patient: _____

Signature: _____ Date: _____

Authorization of PHI Disclosure

I authorize Kiel and New Holstein Family Dental to disclose my health and other information about me and the treatment I am receiving at Kiel and New Holstein Family Dental, included protected health information (PHI) to the following recipients:

-Name of person #1: _____ Relationship to you: _____

-Name of person #1: _____ Relationship to you: _____

Radiographs/Intraoral photos

_____Optional - I grant Kiel Family Dental permission to use my radiographs and photographs for educational and advertising uses. We will not use photos with eyes unless additional verbal/written consent is received.

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	
What is your physician's name and location?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs either prescription or over-the-counter? If so, please list.	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Do you require pre-medication (antibiotics) prior to dental treatment?	◯ Yes ◯ No	If yes	
Are you currently taking a blood thinner?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No		
Do you use tobacco? If yes, what type and quality per day.	◯ Yes ◯ No	If yes	
Have you ever been diagnosed with sleep apnea?	◯ Yes ◯ No	If yes	
Do you snore, or does your partner tell you that you snore?	◯ Yes ◯ No	If yes	
Do you use a CPAP?	◯ Yes ◯ No	If yes	

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
☐ Hay Fever	☐ Cats or dogs	☐ Seasonal allergies	☐ Dairy
☐ Other, please list			

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

Do you currently have, or have you had, any of the following within 7 years?

AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Cortisone Medicine	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Depression/Anxiety	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Angina/Chest Pain	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
Hypoglycemia	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Back Problems	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Swelling of Limbs	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No
Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Tonsils/adenoid removal	◯ Yes ◯ No	Hypothyroid	◯ Yes ◯ No
CPAP use	◯ Yes ◯ No	Mouthbreather	◯ Yes ◯ No	Acid Reflux/GERD	◯ Yes ◯ No	Ear Infections/tubes as a child	◯ Yes ◯ No
Excessive daytime fatigue	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No	Frequent urination	◯ Yes ◯ No	Tinnitis/ringing in the ears	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Dental History

Do you have any of the following?

Sores in mouth or lips	◯ Yes ◯ No	Dry Mouth/Xerostomia	◯ Yes ◯ No	Teeth that are pressure sensitive	◯ Yes ◯ No	Teeth that are hot or cold sensitive	◯ Yes ◯ No
Bleeding gums	◯ Yes ◯ No	History of gum disease treatment	◯ Yes ◯ No	History of orthodontics	◯ Yes ◯ No	Pain in your jaw joints	◯ Yes ◯ No
Clenching or grinding of your teeth	◯ Yes ◯ No	Are you happy with your smile?	◯ Yes ◯ No	Do you wear a night guard:	◯ Yes ◯ No		

If you answered yes to any above please describe here:

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:_____

EPWORTH SLEEPINESS SCALE

Name_____DOB_____

Date _____Gender_____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

Even if you have not done some of these things in the last month, try to imagine how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 - Would **never** doze

1 - **Slight** chance of dozing

2 - **Moderate** chance of dozing

3 - **High** chance of dozing

*****It is important that you answer each question as best as you can.*****

Situation	**Chance of dozing** (out of 3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (eg. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total out of 24	

Score Interpretation:

(1-10) Normal Range (10–16) Excessively sleepy (16-24) Abnormally sleepy