Sierra Cosmetic Dental Center

Richard A. Klein DDS 775 883-0565

Smile makeovers of exceptional distinction and beauty.

Chart #___
FOR OFFICE USE ONLY

Patient Information

Patient Name:_____ Spouse:_____ Date: _____
Last, First MI (Preferred Name)

Mailing Address:_____
Street Apartment # City State Zip Code

Social Security #:_____ Gender:_____ Birth Date:_____ Family Status:_____

Phone (Home): - _____ (Cell Phone):_____ (Work):_____ Ext:_____ e-mail:_____

Occupation:_____ Employer:_____
Company Street City State Zip Code

Sierra Cosmetic Dental Center is very concerned about maintaining the best health possible of its patients and the overall community. If upon arrival for your appointment or during treatment we have reason to suspect that you may have a contagious stage of a communicable illness, we will need to postpone your treatment until you get medical clearance from your medical doctor.

I am interested in:

☐ Resolving Tooth Sensitivity ☐ Arresting Decay ☐ Retaining my teeth ☐ Teeth Whitening ☐ Improving my Smile ☐ Cosmetic Restoration

Health History

Date of last dental visit:_____ Treatment Received: _____ Dentist:_____

Your health history is essential in providing excellent care. Please check each box and comment as appropriate:

Yes No

☐☐ AIDS / HIV
☐☐ High Blood Pressure
☐☐ Anemia
☐☐ Anaphylaxis
☐☐ Arthritis
☐☐ Artificial Joints
☐☐ Asthma
☐☐ Blood Disease
☐☐ Breathing Problem
☐☐ Cancer:_____
☐☐ Chest Pain
☐☐ Coronary Disease
☐☐ Diabetes
☐☐ Dizziness
☐☐ Eating Disorder
☐☐ Epilepsy
☐☐ Excessive Bleeding

Yes No

☐☐ Fainting
☐☐ Glaucoma
☐☐ Growths
☐☐ Hay Fever
☐☐ Head Injury
☐☐ Heart Disease
☐☐ Heart Murmur
☐☐ Hepatitis Circle: A B C
☐☐ Jaundice
☐☐ Kidney Disease
☐☐ Liver Disease
☐☐ Lung Disease
☐☐ Mitral Valve Prolapse
☐☐ Nervous Disorder
☐☐ Pacemaker
☐☐ **Pregnancy** Due date:_____
☐☐ Prosthetics: _____
List:_____

Yes No

☐☐ Psychological Disorder
☐☐ Radiation Treatment
☐☐ Rheumatic Fever
☐☐ Rheumatism
☐☐ Sinus Problem
☐☐ Stomach Problem
☐☐ Stroke
☐☐ Tobacco Use
☐☐ Tuberculosis
☐☐ Tumor: _____
☐☐ Ulcers
☐☐ Venereal Disease
☐☐ **Codeine Allergy**
☐☐ **Penicillin Allergy**
☐☐ **Sulfa Allergy**
☐☐ **Latex Allergy**
☐☐ **Other Allergies:**
_____

Yes No

_____
_____

☐☐ **I require antibiotics before Dental Tx.**

List:_____
_____

Emergency Notification:

_____
Spouse/Parent phone

_____
Friend/Relative Not Living with you phone

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, enter: _____
- Are you currently under the care of a physician? ☐ Yes ☐ No
  If yes, enter: _____
- Name of Primary Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

LIST ALL MEDICATION YOU ARE CURRENTLY TAKING:_____

_____

_____ Date: _____
Signature of patient, parent or guardian

Financial Guarantor

Guarantor's Name: ---------- Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Guarantor's Address: _____
Street Apartment # City State Zip Code

Guarantor's Occupation: _____ Social Security #: _____ Birth Date: _____ ☐ Male ☐ Female

Guarantor's Employer: _____
Company

Employer's Address: _____
Street City State Zip Code

Guarantor's Phone; (Home): _____ (Cell Phone): _____ (Work): _____ Ext: _____

Dental Insurance Carrier

Primary Insurance Carrier: _____ Policy #: _____ Group Plan: _____

Carrier's Billing Address: _____
PO Box Street City State Zip Phone Ext.

Subscriber's Name: _____ Social Security #: _____ Birth Date: _____
If Different from Guarantor If Different from Guarantor If Different from Guarantor

Relationship of Subscriber to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Secondary Insurance Carrier: _____ Policy #: _____ Group Plan: _____

Carrier's Billing Address: _____
PO Box Street City State Zip Phone Ext.

Subscriber's Name: _____ Social Security #: _____ Birth Date: _____
If Different from Guarantor If Different from Guarantor If Different from Guarantor

Relationship of Subscriber to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

_____
Subscriber's Signature Date

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
PHOTO CONSENT and COMMUNICATION CONSENT
Communication: Reminder Calls, E-Mail, and Text messaging will be used to make and confirm appointments only.

Dear Dr. Klein,
I hereby consent to the use of my photographs, video, x rays, models, for dental labs, publication for student and patient education aids, procedure albums, as well as reprinted copies, digitized computer copies and computer imaged copies for either professional or commercial use by Richard A. Klein D.D.S or his assignee. Further, I release Richard A. Klein, D.D.S. and any publisher or other user of these photographs from any liability regarding their usage.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.83% per month (22% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition here-under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted here-under.

I grant my permission to you or your assignee, to text, telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment / responsible party