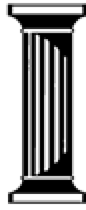

Sierra Cosmetic Dental Center
Richard A. Klein DDS 775 883-0565
Smile makeovers of exceptional distinction and beauty.

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
- ☐☐ Allergies:__________
  List:__________
- ☐☐ 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: __________

Yes No
List:__________
- ☐☐ 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**
- ☐☐ **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

Dear Dr. Klein,

I herby 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 hereunder 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 hereunder.

I grant my permission to you or your assignee, to 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