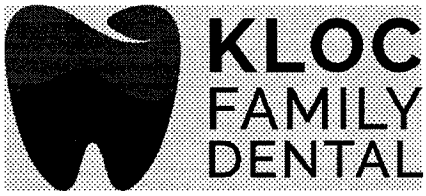

67 West Main Street
Honeoye Falls, NY 14472
(585) 624-2910
klocfamilydental.com
info@klocfamilydental.com

Dear _____)

We are delighted to welcome you to Kloc Family Dental! Thank you for trusting our friendly team to provide you with exceptional dental care. We provide a wide range of services including preventative and restorative care.

In preparation for your first visit, we have enclosed new patient information including a registration form and dental/medical history questionnaires. Also included are forms regarding our privacy and financial policies. In order to make your visit a great experience, please complete these forms prior to your first appointment. **As always, please contact our office if you have any questions or need assistance.**

If you have dental insurance, please bring your insurance card with you to your first visit. Kloc Family Dental participates directly with Excellus BlueCross BlueShield and will submit claims on your behalf. We welcome patients of many other insurances, who will issue payment directly to the subscriber - therefore, payment is due in full on the date of service. We will provide you with a completed insurance claim form to mail to your insurance company for reimbursement. For your convenience, we accept payment with Visa, Master Card, Discover, and American Express credit cards, as well as cash and check. We also participate with Care Credit.

We look forward to meeting you! We are committed to taking care of our patients' oral healthcare and always do so with great skill, kindness, and compassion. Thank you for choosing Kloc Family Dental as your dental home!

Sincerely,

Dr. Daniel Kloc, DDS

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

Cell phone-_____ Home phone _____ Work phone _____ If minor, parent names _____

Mailing address _____ City _____ State _____ Zip _____

Employer _____ Spouse's Name_____ Spouses DOB_____

Email Address _____ ❑ Male ❑Female Best way to confirm appointments _____

Whom may we thank for referring you to our office? _____

Emergency Contact_____ Phone number: _____ Relationship-_____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

Cancer or tumor	❑ yes	❑ no
Heart Disease	❑ yes	❑ no
Heart murmur/defect	❑ yes	❑ no
Mitral valve prolapse	❑ yes	❑ no
Rheumatic fever/disease	❑ yes	❑ no
Artificial joint or valve	❑ yes	❑ no
High/low blood pressure	❑ yes	❑ no
Pacemaker	❑ yes	❑ no
Tuberculosis	❑ yes	❑ no
Kidney disease	❑ yes	❑ no
Hepatitis/liver disease	❑ yes	❑ no
Alcoholism	❑ yes	❑ no
Addiction	❑ yes	❑ no
Blood transfusion	❑ yes	❑ no
Diabetes Type ____	❑ yes	❑ no
Neurologic condition	❑ yes	❑ no
Epilepsy/Seizures	❑ yes	❑ no
Fainting spells	❑ yes	❑ no
Emotional condition	❑ yes	❑ no
Arthritis	❑ yes	❑ no
Herpes or cold sores	❑ yes	❑ no
AIDS or HIV positive	❑ yes	❑ no
Migraine headaches	❑ yes	❑ no
Frequent headaches	❑ yes	❑ no
Anemia/blood disorders	❑ yes	❑ no
Abnormal bleeding	❑ yes	❑ no
Hayfever or sinus trouble	❑ yes	❑ no
Allergies or hives	❑ yes	❑ no
Asthma	❑ yes	❑ no
Sleep apnea/Suspected	❑ yes	❑ no
Tobacco use	❑ yes	❑ no How much _____

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following? (attach list if needed)

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Vitamins
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Bisphosphonates- Oral or IV
- ❑ Other_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____ Ph#_____ Previous Dentist _____

Do you have any disease, condition, or problem not listed above?_____

Signature of patient (or parent) _____ Date _____

Office Financial Policy
Kloc Family Dental
67 West Main Street
Honeoye Falls, NY 14472

Welcome to Kloc Family Dental. Thank you for choosing our office for your dental care needs. **This agreement is to inform you of your financial obligations to our practice, and is intended to facilitate our ability to provide you with excellent service while making you informed of our policies.**

1) All charges you incur are your responsibility regardless of your insurance coverage.
    a) As a courtesy to our Excellus BlueCross BlueShield patients, we will process and submit your insurance claim(s). Your estimated portion of treatment, which is the amount not covered by your insurance, is due in full at the time service is provided (unless arrangements have been made prior to your appointment). If, for any reason, your insurance company denies or fails to cover your claim, you are responsible for payment in full.
    b) Our office is out-of-network (non-participating) with all insurance companies other than Excellus BlueCross BlueShield. We welcome patients of many other insurances, who will issue payment directly to the subscriber - therefore, payment is due in full on the date of service. We will provide you with a completed insurance claim form to mail to your insurance company for reimbursement.

2) Your dental insurance policy is a contract between you and your insurance company. It is your responsibility to know your maximums, dental coverage information, and deductible information. It is essential that you understand your specific group's dental coverage. You are ultimately responsible for all services regardless of coverage.

3) Our office accepts payment in the form of credit cards (Visa, Master Card, Discover, American Express), cash, check, and Care Credit.

4) Returned checks are subjected to a $25.00 service charge and may terminate your privilege to pay by check in the future.

5) All outstanding balances exceeding 60 days (excluding outstanding insurance claims) will be sent to our collection agency. It is understood and agreed that in this event, you will be fully responsible for all collection agency fees and attorney fees.

6) If there are repeated broken appointments or canceled appointments with less than 48 hours notice there may be a $40.00 charge applied to your account.

Please sign and date below to indicate that you have read and fully understood said policy.

Patient Name: _____
Signature: _____
Date: _____

Acknowledgement of Receipt of Privacy Practices and Information Authorization

Kloc Family Dental
67 West Main Street
Honeoye Falls, NY 14472

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g my insurance company)
- The day to day healthcare operations of our practice

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosure of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions; however, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any used disclosure that occurred prior to the date that I revoke this consent is not affected.

I understand and acknowledge my rights as detailed in the Notice of Privacy Practices presented here.

I understand and consent to my medical information being used as described here.

I understand the terms and authorize the practice to disclose my medical information to those parties as mentioned here.

Please specify your relationship to the patient: _____
Signature of patient or representative: _____
Date: _____

For Kloc Family Dental to disclose private health information about you to parties not covered in our Notice of Privacy Practices, you will need to complete this section.

□ Yes, you may provide information to the parties listed below:

_____

□ No, I do not wish Kloc Family Dental to discuss my information with any party other than myself.

Signature of patient or representative: _____

Date: _____