



Dr. Ericka Klein, D.M.D., P.C.
Cosmetic and General Dentistry

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Welcome to our office! We appreciate the confidence and trust that you have placed in us and look forward to meeting you. Our goal is to provide the best possible dental care for our patients. Our philosophy of care governs everything we do. It consists of the following key elements:

- We recognize that each patient is an individual and our goal is to help you retain your teeth in comfort, function and esthetic for lifetime.
- We want you to feel comfortable with our entire team.
- We strive to be thorough, taking the time to be the best we can be.
- We are a mercury free office. All material we use are amalgam free.

We provide a wide array of appointment times from 7AM to 5PM for your convenience. We try to accommodate all emergency appointments on the same day. Should you need to reschedule your appointment, we respectfully request that you provide us with at least 2 business days' notice. We currently have a \$75.00 charge if an appointment is rescheduled with less than 24 hours' notice.

We utilize electronic statements via email. Secure online payment is available through our website. Paper statements may be requested, if preferred.

Our office is conveniently located on the second floor of the Devon Professional Building, which is just west of Waterloo Avenue and east of Devon Manor on the north side of Lancaster Avenue right across from the Devon Audi Dealership. We have ample parking and are handicap accessible.

Enclosed is our new patient information form. Please complete and sign both sides of the form and bring to your first appointment along with a list of your current medications (if any.) If you have dental insurance, please bring your ID card.

We look forward to working together to promote your dental health.

Sincerely,
Ericka Klein D.M.D., P.C.

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

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ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
Last _____ First _____ Mi _____ Mr _____ Mrs _____ Ms _____ Dr _____

I prefer to be called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Home Address: _____ Apt/Condo # _____

City _____ State _____ Zip _____

Single Married Partnered Divorced/Separated Widowed

Hm #: (____) _____ Cell / Other #: _____

Wk #: (____) _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

City _____ State _____ Zip _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Person Responsible for Account: _____

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SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Contact #: (____) _____ Ext: _____ SS #: _____

Birthdate: ____ / ____ / ____ DL #: _____

Relative or Friend not living with you (for emergency).

His / Her Name: _____ Relation: _____

Contact #: (____) _____

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INSURANCE

Primary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City _____ State _____ Zip _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

City _____ State _____ Zip _____

Secondary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City _____ State _____ Zip _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

City _____ State _____ Zip _____

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date _____

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MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (_____) Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription / over-the-counter drugs? Yes No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

| | | | |
|---|------------------------------------|---|------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Abnormal Bleeding / Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N | Herpes / Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N | AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N | High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Alcohol / Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N | HIV |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N | Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N | Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N | Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N | Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N | Psychiatric Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N | Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N | Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N | Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N | Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N | Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N | Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N | Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Attack / Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N | Ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N | Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

| | | | | | |
|---|--------------------|---|----------------|---|--------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N | Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N | Penicillin |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N | Jewelry/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N | Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N | Latex | <input type="checkbox"/> Y <input type="checkbox"/> N | Other |

Please list any other drugs/materials that you are allergic to:

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit?

If Yes, please explain: _____

Y N

Patient Signature

Date

Dentist Signature

Date

Has there been any change in your health status since your last visit?

If Yes, please explain: _____

Y N

Patient Signature

Date

Dentist Signature

Date



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices for the office of Ericka Klein, D.M.D., P.C.

Print Name

Signature

Date

Please list the persons with whom we may discuss your health information.

Name: _____ Phone# _____

Relationship to patient: _____

Name: _____ Phone# _____

Relationship to patient: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify): _____
