purefamilydentistry
Shane Klingonsmith DMD

Welcome to our family of remarkable caregivers and patients. We are grateful that you have chosen to be a part of our lives. We are excited to be a part or yours. Our hope is to make you feel safe, comfortable and at home, while providing exceptional service.

We are different from the average dental practice. When you visit our office you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed expectations. We use the latest technology, materials and techniques our profession has to offer.

During your first visit, Doctor Shane Klingonsmith will examine your teeth, perform an oral cancer exam, review necessary x-rays and make an assessment for your oral health. Staff members will assist the Doctor in completing your oral health evaluation and you will be meeting several members of our dental team.

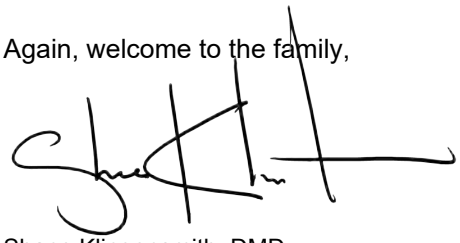
If it is discovered that you need any dental treatment, we will discuss our findings and recommend one or more treatment plans to fit your comfort level, cosmetic expectations and budget. If you have dental insurance benefits, it will be helpful for you to give your insurance card or plan information to our front office person.

For your convenience, we have enclosed a health questionnaire and other information about our office policies. If you have any questions, feel free to call us at (610) 866-0552.

Please fill out the enclosed questionaire prior to your first appointment with Dr. Shane.

Be sure to visit our website at ***www.purefamilydentistry.com*** or "like" us on **Facebook** to keep current on office specials and promotions. We are continually looking to improve our service and also enjoy hearing how we are meeting and exceeding expectations.

Again, welcome to the family,



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REGISTRATION AND HEALTH HISTORY

Date: _____ (Enter as MM/DD/YYYY)

First Name: _____ M.I. ____ Last Name: _____ ☐ male ☐ female Date of Birth: _____ (Enter as MM/DD/YYYY) Age: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Social Security#: _____ (Do NOT include dashes or spaces)

Email Address: _____ Emergency Contact: _____

Marital Status: ☐ Married ☐ Single Student: ☐ Full-time ☐ Part-time ☐ N/A Occupation: _____

What would you prefer to be called? _____ Who may we thank for this referral? _____

Family Physician: _____ Phone#: _____

Dental Insurance Carrier: _____ ID#: _____ Group #: _____

☐ Check this box ***ONLY*** if the Insured person *(the person receiving dental service)* is the same as applicant above. If not, enter Insured info below.

Name of Insured: _____ Insured's SS#: _____ (Do NOT include dashes or spaces) Insured's Date of Birth: _____ (Enter as MM/DD/YYYY)

Relationship to Insured: _____

Employer of Insured: _____ ☐ Full-time ☐ Part-time ☐ Retired Phone#: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Who is financially responsible for this account? _____ Phone#: _____

Please select Y = Yes or N = No if you have any of the following conditions:

☐Y ☐N - Anemia	☐Y ☐N - Arthritis	☐Y ☐N - Artificial Joints	☐Y ☐N - Asthma
☐Y ☐N - Blood Disease	☐Y ☐N - Cancer	☐Y ☐N - Diabetes	☐Y ☐N - Dizziness
☐Y ☐N - Epilepsy	☐Y ☐N - Excessive Bleeding	☐Y ☐N - Fainting	☐Y ☐N - Glaucoma
☐Y ☐N - Head Injuries	☐Y ☐N - Heart Disease	☐Y ☐N - Heart Murmur	☐Y ☐N - Hepatitis
☐Y ☐N - High Blood Pressure	☐Y ☐N - HIV	☐Y ☐N - Jaundice	☐Y ☐N - Kidney Disease
☐Y ☐N - Liver Disease	☐Y ☐N - Mental Disorders	☐Y ☐N - Nervous Disorders	☐Y ☐N - Other
☐Y ☐N - Pacemaker	☐Y ☐N - Pregnancy	☐Y ☐N - Radiation Treatment	☐Y ☐N - Respiratory Problems
☐Y ☐N - Rhematic Fever	☐Y ☐N - Rheumatism	☐Y ☐N - Sinus Problems	☐Y ☐N - Stomach Problems
☐Y ☐N - Stroke	☐Y ☐N - Tuberculosis	☐Y ☐N - Tumors	☐Y ☐N - Ulcers
☐Y ☐N - Venerial Disease			

Other conditions not listed: _____

Are you allergic to latex, soy, egg, milk, dairy or nuts products? _____

List any antibiotics, anesthetics or other drug allergies: _____

List all prescription/OTC medications, vitamins and/or supplements you are presently taking: _____

_____

Do you have any disease, organ transplant, or take any medication which may depress your immune system? _____

Do you have, or have you ever had clicking, popping or pain in your tempromandibular joints (TMJ)? _____

Have you been hospitalized in the past five years? ☐ Yes ☐ No If yes, why? _____

Do you take aspirin on a daily basis? ☐ Yes ☐ No If yes, why? _____

Are you under a physician's care presently? ☐ Yes ☐ No If yes, why? _____

Have you ever been a drug or substance abuser? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No How much? _____

Is there anything you would like to discuss with the Doctor in private? _____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing his treatment on this information. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to Pure Family Dentistry unless otherwise indicated.

Signature: _____ **Date:** _____ (Enter as MM/DD/YYYY)

*Your signature indicates you have received a *copy of the HIPAA law* and authorize Dr. Klingonsmith to utilize any dental photographs for lecturing and education purposes, within HIPAA's requirements of protection and confidential handling of protected health information.

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DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____ *(Enter as MM/DD/YYYY)*

What is your primary concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies? ☐ Yes ☐ No

If so, explain: _____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

_____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth? ____ time(s) a select... How often do you floss? ____ time(s) a select...

What type of brush do you use? ☐ Manual ☐ Powered

Do you avoid brushing any part of your mouth because of pain? ☐ Yes ☐ No If yes, what part? _____

Which foods cause you twinges of pain: ☐ Hot ☐ Cold ☐ Sweet ☐ Sour ☐ None

Do your gums feel tender or swollen? ☐ Yes ☐ No

Do you chew on only one side of your mouth? ☐ Yes ☐ No If yes, explain: _____

Do you clench or grind your jaws while sleeping or during the day? ☐ Yes ☐ No Do your jaws ever feel tired? ☐ Yes ☐ No

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? ☐ Yes ☐ No Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = Awesome): ____

Would you like to have whiter teeth? ☐ Yes ☐ No

If you had a magic wand, what, if anything, would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Would you like a new or improved smile? ☐ Yes ☐ No **If yes, please select all that apply:**

☐ Lighten all front teeth	☐ Rebuild fracture(s)	☐ Straighten rotation	☐ Eliminate dark or stained fillings
☐ Lighten single tooth	☐ Lengthen	☐ Straighten angulation	☐ Reduce gum showing in smile
☐ Close spaces between teeth	☐ Shorten	☐ Eliminate crowding	☐ Repair uneven edges

Please add anything you feel is important:

At Pure Family Dentistry, our team delivers cosmetic restorations and high quality routine general dental care. For complex cases or complete smile make-overs, flexible payment plans, as well as phasing treatment over time, can provide you and your family access to spectacular long-term results. We look forward to the opportunity to be of service.

Warm Regards,
Shane Klingonsmith, DMD

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Full Name: _____ Telephone: _____ Social Security#: _____
(Do NOT include dashes or spaces)

Address: _____ City: _____ State: _____ Zip: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at 610-866-0552 or by mailing us at 4555 Easton Avenue, Bethlehem, PA 18020.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ **Relationship:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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COMFORT MENU

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times.
Please select from the following options:

- Patients find that if they take an analgesic prior to treatment it helps later in the day.
  Which would you prefer? ☐ Tylenol ☐ Advil ☐ Other: _____

- We provide various levels of sedation to ease your mind.
  Would you benefit from a sedative?..... ☐ Yes ☐ No

  If yes, we provide: ☐ Nitrous Oxide (laughing gas)
  ☐ Mild sedative (oral medication)
  (Note: With mild sedative, you will need someone to drive you to the appointment.)

- Our treatment rooms are equipped with HDTVs and Netflix on demand video. Watching TV or a movie is an excellent way to pass the time during your visit.
  Would you like to watch HDTV during your visits?..... ☐ Yes ☐ No

- We also have Wireless headphones and with online on demand music services (tens of millions of songs).
  Would you like to listen to music during your visits?..... ☐ Yes ☐ No

- Complimentary WiFi Internet access is available for your use throughout the office. Please feel free to bring your wireless Internet device with you for each visit.

- Blankets help keep you warm and relaxed through your visit.
  Would you like a blanket?..... ☐ Yes ☐ No

- Pillows provide an extra measure of comfort if you have a sore back or neck.
  Would you like a pillow?..... ☐ Yes ☐ No

- Is there anything else we can do to make your visit comfortable?

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Completion Instructions

Thank you for taking the time to complete our New Patient Welcome Packet. If everything is correct, please print pages 2 - 6 and bring them in on your first appointment visit. In addition, you may submit this entire packet electronically to Pure Family Dentistry by pressing the "**Submit via E-mail**" button below and following the on-screen instructions. **E-mail does not work on all devices, so "If in doubt, please, print it out."**

After successfully printing the document and verifying that everything is correct and fully complete, you may erase all form content by pressing the reset button below. Or, you may delete the entire file from your device, if saved.

If you have questions regarding these instructions, please contact our office at (610) 866-0552.

Thank you and Welcome!
Shane Klingonsmith, DMD

Print Form

Submit via E-mail

NOTE: Before resetting this document, please make sure you have a correct and fully completed printed copy.
(Resetting document will permanently erase all entered data!)

Reset Form