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

Be sure to visit our website at ***www.purefamilydentistry.com***. We are continually looking to improve our service and also enjoy hearing how we are meeting and exceeding expectations.

Again, welcome to the family,

Shane Klingonsmith, DMD

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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 ________ How often do you floss? ____ time(s) a ________

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
- ☐ Lighten single tooth
- ☐ Close spaces between teeth
- ☐ Rebuild fracture(s)
- ☐ Lengthen
- ☐ Shorten
- ☐ Straighten rotation
- ☐ Straighten angulation
- ☐ Eliminate crowding
- ☐ Eliminate dark or stained fillings
- ☐ Reduce gum showing in smile
- ☐ 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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PATIENT AGREEMENT

It is our goal for you to clearly understand your treatment needs, as well as your financial responsibilities, before treatment begins. Efficient and effective office policies help us keep treatment affordable for all our patients. In order to achieve these goals, we need your assistance and your understanding of our office policies and the limitations of your dental insurance.

Dental insurance is designed to help reduce your out-of-pocket cost for treatment. Our responsibility is to provide you with the treatment that best meet your needs, not to match your needs to you insurance plan limitations. All plans have limitations. The limitations of your plan are typically negotiated by your employer and greatly determined by your employer's financial contribution on your behalf. Many routine and necessary dental services are not covered or only partially covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company, we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatement is completed and the claim is submitted.

A) Insurance Policies

I understand my dental insurance is a contract between be me, my employer and my benefit company only; therefore, all charges are my responsibility. I understand fees vary with the complexity of treatment and are are closely estimated prior to the beginning of treatment. I understand Pure Family Dentistry files my dental insurance claims as a courtesy, and has no involvement in how benefits are determined.

B) Financial Agreement

For your convenience, we accept Visa, MasterCard, Discover Card, and Care Credit. Payment of your estimated portion is due at the time service is rendered. After we help you submit the charges to your benefit company, by law, your insurance company is required to make payment or deny a claim within 30 days. If the remainder of your claim is not paid in full, statements are mailed monthly and you are expected to pay the balance in full.

I understand that I am responsible for all fees for services rendered. I understand that an interest of 1.5% per month will be charged on any unpaid balance after 60 days. In case of total default I agree to pay an additional 30% of my delinquent balance to cover all costs for collection including but not limited to interest, court costs, sheriff fees, attorney fees and collection costs that may be incurred to collect on this account.

I am aware that any parent or guardian bringing a child to our office is legally responsible for the payment of services rendered.

C) Scheduling Policy

Your time is valuable and we are commited to seeing you on schedule. Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

I understand that if I need to change my appointment, I will notify Pure Family Dentistry within two business days (48 hours) of my scheduled appointment. For excessive missed appointments, I understand that I might be charged a missed appointment fee of $85.

PATIENT AGREEMENT: PLEASE INQUIRE IF YOU HAVE ANY QUESTIONS.

I, ________________________________ certify that I have read, fully understand, and accept the above patient agreement.

Signature: ____ **Date:** ______________________

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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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