



Welcome to our practice! We are pleased that you have chosen us to meet your dental needs. Our mission is to serve our patients with compassion and empathy while providing excellent comprehensive dental care in a friendly, safe, and relaxed environment.

Getting to know you personally and assessing your dental needs, is our main objective during your initial visit to our office. **Please help us give you the time and attention you deserve by completing the patient registration, medical history and privacy notice forms BEFORE YOU ARRIVE.**

As soon as possible, please contact your previous dental office and have ALL CURRENT DENTAL RADIOGRAPHS and pertinent treatment notes transferred to our office. We want this transition to be as smooth as possible for you, so please call us if you need assistance. Patients are encouraged to start this process several weeks before the initial visit to allow sufficient time for duplication and shipping. All necessary radiographs will be taken during your initial visit unless we have received current radiographs of diagnostic quality from your previous dental office.

Please bring your insurance card, the name of the employer and the social security number of the person who is the insurance subscriber. We will be happy to assist you in any way we can with your insurance. Please remember that regardless of dental insurance coverage, payment remains your personal responsibility. Insurance co-payments, fees for non-covered services and all other payments are expected at the time of your appointment. If you are unable to pay at the time of service, financial arrangements must be made prior to your appointment.

During your first visit, we will conduct a thorough examination. This examination will include a complete head and neck examination, a thorough examination of your mouth, teeth and gums, along with any necessary x-rays. Afterward, we will discuss the findings of your examination and work together to create a plan the best meets your individual needs and goals.

We recognize the value of your time. Except in emergency situations, you can expect us to be on time for you. We appreciate the same courtesy. If for some reason you cannot make your appointment, we ask that you notify us at least 48 hours in advance.

Our office is located near the NE corner of Ivanrest and 44th Street. Parking is available near the front entrance.

Should you have any questions, please call. We are looking forward to a relaxed and pleasant visit with you.

Sincerely,

Douglas R. Klein, D.D.S.



Dental Insurance or Dental Assistance?

Dental Benefits are **NOT** really *Insurance* in the classic sense.

*If you have needs other than healthy cleanings, your care **will** require an investment beyond what your “insurance” will cover. Your benefits will assist you in the maintenance of your dental health but were never designed to be all you need.*

It's not news that employers have reacted to the rising costs of health care benefits by shopping carefully for the insurance policies that they offer their employees. Benefits are down, restrictions and exclusions are up. Our patients share their resulting frustration with us every day. Adding to the frustration is the fact that dental benefits are often represented as being comparable to other types of insurance. “Insurance”, by definition, is protection against unpredictable or catastrophic loss. But most dental insurance policies specifically *exclude* extraordinary needs. The things offered as benefits are not only predictable, but expected, such as routine exams, x-rays, healthy cleanings, etc. Further, policies that do offer a benefit of other common services, such as crowns and treatment for gum disease, provide them at a much lower percentage of the actual cost of providing that care, and with a low dollar limit per year.

Your dental benefit plan is an excellent maintenance assistance program that will help you protect your investment in your dental health, and we're happy you have that assistance!

Another common misrepresentation is that dental “insurance” covers all of the things that you need. We believe this can be a danger to your health, because **it implies that if it isn't covered, you don't need it.** Insurance companies are in business to make money. This is no secret and it's not bad or wrong. Their responsibility to their shareholders is to provide the benefits they can while still creating profit within the investment your employer has chosen to make in dental health. You cannot count on a dental benefit plan to determine what you need; that's your responsibility. It's our responsibility to advise you regarding your health. The fact is, unless you have excellent dental health, your needs will require that you make an investment.

We invest in what we value. Home improvement, education, vacations, are all examples of things we pay for, by choice, because we value them. We don't presume to know where dental health fits in your value system. That's for you to decide. It's important for us that you know we think you're worth the investment, and we'll work with your benefit plan to see that you receive the maximum benefits in assisting you with the maintenance of your health.

We work with and welcome ANY questions about your dental benefit plan



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (Jan. 1, 2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Michigan's Dental Patient Consent Law: We are required by Michigan Law to obtain your written consent prior to making certain disclosures of your health information.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information as required to by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, the fee is \$5.00 for each page or \$35.00 per hour for staff time to locate and copy your health information, plus postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Sherry Hamilton

Telephone: 616-538-4960

Fax: 616-538-4999

Address: 3185 Macatawa Drive, Suite C, Grandville, MI 49418



Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as a part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient Signature

Patient Name (please print)

Date

FOR OFFICE USE ONLY

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement.

An emergency situation prevented the patient from signing the Acknowledgement.

Office Personnel (print name)

Office Personnel (signature)

Date

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be the type listed above.

Patient Signature

Patient Name (please print)

Date

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: Policy Holder Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____

Last Name: _____

Middle Initial: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Birth Date: _____

Soc Sec: _____

Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address: _____

Address 2: _____

City: _____

State / Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Sex: Male Female

Marital Status: Married Single

Divorced

Separated

Widowed

Birth Date: _____

Age: _____

Soc Sec: _____

Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired

Cellular # _____

Student Status: Full Time Part Time

Medicaid ID: _____

Pref. Dentist: _____

Employer ID: _____

Pref. Pharmacy: _____

Carrier ID: _____

Pref. Hyg: _____

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

HEALTH HISTORY

Indicate which of the following you have had or have at present. A checked box will indicate a "yes" response, leaving an unchecked box will indicate a "no" response.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> *pre-medication | <input type="checkbox"/> artificial joints | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> arthritis | <input type="checkbox"/> celiac disease | <input type="checkbox"/> herpes/cold sores |
| <input type="checkbox"/> valve replacement | <input type="checkbox"/> glaucoma | <input type="checkbox"/> liver disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> pacemaker | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> nervous disorders |
| <input type="checkbox"/> stent | <input type="checkbox"/> cancer | <input type="checkbox"/> stroke | <input type="checkbox"/> mental disorders |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> radiation treatment | <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> psychiatric care |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> headaches | <input type="checkbox"/> anorexia/bulimia |
| <input type="checkbox"/> infective endocarditis | <input type="checkbox"/> respiratory problems | <input type="checkbox"/> migraines | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> blood thinners | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> fainting | <input type="checkbox"/> jaw pain/locking |
| <input type="checkbox"/> excessive bleeding | <input type="checkbox"/> kidney disease | <input type="checkbox"/> taking birth control | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes- | <input type="checkbox"/> pregnant- | <input type="checkbox"/> snoring |
| <input type="checkbox"/> smoker- current/past | last A1C _____ | weeks along _____ | <input type="checkbox"/> use a C-PAP |

Have you had a serious illness, injury or operation? Yes No

If yes, describe:

MEDICATION List all medications, vitamins and/or supplements taken within the last two years:

ALLERGIES Penicillin Codeine Latex Metals Acrylic Nuts

Other medicine or food allergies:

Name of Physician _____ Phone _____

Print Patient's Name _____

Sign Patient/Parent or Guardian _____

Date _____ Reviewed by _____ BP _____