Dentistry by Kretchmer

New Patient Information

Patient Name: _____ _____ _____ _____
Last First MI Nickname

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ **Birth Date:**_____

Phone (Home): _____ **(Work):** _____ Ext: _____ **(Cell):**_____

Email address: _____

Address:_____
Street Apartment #

_____
City State Zip Code

Spouse or Account Holder Information

The following is for: ☐ **the patient's spouse** ☐ **the person responsible for payment**

Name: _____**Birth Date:** _____**Social Security #:**_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Phone (Home): _____ **(Work):** _____ **(Cell):** _____

Address: _____
Street City State Zip Code

Employer name: _____ **Address:** _____

Referral Information

☐ **Dex St. Paul** (big Dex) ☐ **Dex SE Suburb** (little Dex) ☐ **Cottage Grove Phone Book**

☐ **Val Pak** ☐ **Driving By** ☐ **Delta Dental Provider** ☐ **School** ☐ **Internet**

☐ **Friend/Family:** _____ ☐ **Other**_____

Employment Information

Patient

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary Insurance

Insurance Plan Name: _____ Phone: _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ Social Security/ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary Insurance

Insurance Plan Name: _____ Phone:_____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ Social Security/ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____ __
- ☐ Anemia
- ☐ Artificial Heart Valves
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Drug Dependency
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Premedicate
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Skin Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

Medications: Please list medications you are currently taking: _____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

Emergency contact/nearest relative

Name: _____ **Relationship:** _____

Phone number: _____

Consent for Services

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I understand that my dental needs may change during the course of treatment. The doctor has explained my dental condition, the proposed procedure, and the risks of this procedure. I understand the risks of this procedure, including the risks specific to me and the likely outcomes. The doctor has explained other relevant treatment options and their associated risks. The doctor has explained my prognosis and the risks of not having the procedure. I give my consent to the providers of Dentistry by Kretchmer to perform any necessary treatment I may need.

X_____ Date:_____

Signature of patient, parent or guardian

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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, healthcare operations, and that you received a copy of the office's notice of Privacy Practices.

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. A copy of our Notice accompanies this Consent. 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:

Contact Person: Dr Bob Kretchmer
Telephone: 651-459-3145 Fax: 651-254-7353
Address: 7430 80th S Suite 203 Cottage Grove, MN 55016

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 Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I, the undersigned, understand and agree that there will be an interest charge of 1.5% per month of any past due account over sixty days. I also understand and agree that if I am in default of this agreement, my balance will be sent to a collections agency and I will be responsible for all costs incurred to collect my delinquent account. My increased balance will be calculated by dividing my current unpaid balance by (.65). In the event an attorney would be required, my unpaid balance would be divided by (.50).

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

X_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____