ELGIN FAMILY DENTISTRY
Julee Kingsley DDS Andrea Peters DDS

Welcome to Elgin Family Dentistry!

We realize that you have many options when it comes to dental providers, so we are pleased that you have chosen us for your dental needs. Our team is committed to providing individualized care to your family in an educational and caring environment.

On your first visit, we will listen carefully to your dental concerns and answer any questions you might have. You can expect a thorough oral examination, including any necessary x-rays, and a discussion of the best treatment to meet your oral health goals.

Enclosed you will find our health questionnaire. For your convenience and to allow us to make the most efficient use of your time, please complete it and either drop it off at our office, e-mail it back to us, or come 10 minutes prior to your first scheduled appointment.

If you would like to know more about our practice, you can visit our website at www.elginfamilydentistry.com. You can also view directions to our office, the latest practice news, and dental tips.

You can also email us at elginfamilydentistry@gmail.com with questions or concerns, and we will do our best to respond within 24 hours.

Thanks again for your confidence in our dental team; we look forward to seeing you soon!

Sincerely,

Dr. Julee Kingsley, Dr. Andrea Peters and the team at Elgin Family Dentistry

124 2nd Avenue SE
Elgin, MN 55932

Phone: (507)876-0127
Fax: (507)876-0109

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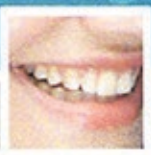
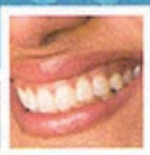
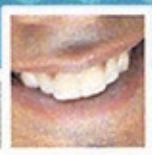

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

When was your last visit to the dentist? What was done at this time? (check-up and cleaning, filling, etc.)

* _____

Do you have a fear of the dentist or dental cleanings/treatment?

* ◯ Yes ◯ No

If yes, why?

_____

Have you had any problems or complications during previous dental treatment?

* ◯ Yes ◯ No

If yes, please explain:

_____

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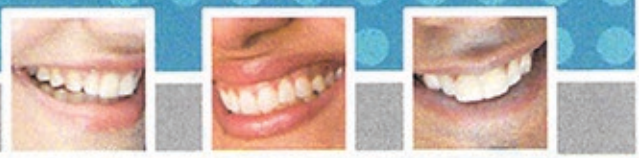

Are you pleased with the overall appearance of your teeth or is there anything that you'd like to discuss with us about improving your smile? (i.e. I'd like to whiten my teeth, straighten my teeth, replace unattractive older fillings, etc.)

*

Do your gums bleed when you brush or floss?

* ◯ Yes ◯ No

Do you have any areas that food is constantly getting stuck?

* ◯ Yes ◯ No

How often do you brush your teeth?

* ◯ less than 1/day
◯ 1/day (usually in the morning)
◯ 1/day (usually at night)
◯ 2/day
◯ 3+/day

What best descibes how often you floss?

* ◯ I don't floss
◯ rarely (when I get something stuck)
◯ occasionally/sporadically
◯ at least 1/week
◯ daily
◯ multiple times a day

Do you use anything else to clean your teeth?

☐ Automatic/electric toothbrush
☐ Floss handle or floss-pick
☐ Rubber-tip stimulator
☐ Tooth picks/wooden stimudents
☐ Water-pik
☐ Proxybrush
☐ Soft Picks
☐ Listerine/CrestProhealth
☐ Other

On a scale of 1-5 (1 being least important and 5 being most important) how important is it to you to keep your teeth? (Feel free to explain if necessary.)

*

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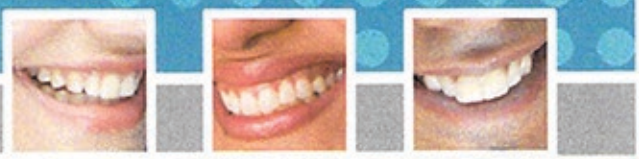

Are your teeth sensitive to:

* ☐ Hot ☐ Cold ☐ Sweets
☐ Biting down/Chewing ☐ Pressure ☐ No Sensitivity

Additional comments:

Do you have any reason to believe that you clench or grind your teeth (often done while sleeping)?

* ◯ Yes ◯ No

Additional comments:

Do you ever experience:

☐ Jaw pain
☐ Jaw locking open or closed
☐ Pain or jaw exhaustion while chewing or upon waking
☐ Chronic headaches
☐ Popping or clicking of your jaw
☐ Chronic ear aches

Additional comments:

Have you ever had:

☐ Braces ☐ Gum Surgery ☐ Dental Implants
☐ Root canal therapy ☐ Partial or full dentures ☐ Wisdom teeth removed

Additional comments:

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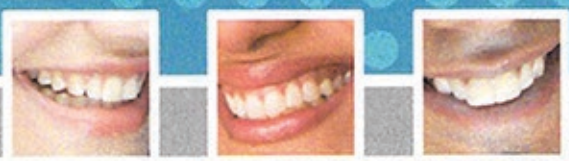

Whom may we thank for your referral to our practice? What is the reason for your visit with us today?

*

Do you use tobacco products?

* ◯ Yes ◯ No

If yes:

How long have you used tobacco?

How much tobacco do you consume?

Have you ever tried to quit?

◯ Yes ◯ No

Are you interested in learning more about how we could assist you in quitting?

◯ Yes ◯ No

Office use only : Notes

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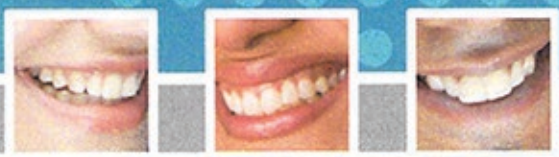

Patient Name:* _____ (Last) * _____ (First) _____ (MI) _____ (Preferred Name)

Do you have or have you ever had any of the following?

* ☐ Acid Reflux	☐ Allergy - Latex	☐ Allergy - Metals
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Allergy - Other
☐ Alzheimers	☐ Anemia	☐ Anxiety
☐ Arthritis	☐ Artificial Heart Valves	☐ Artificial Joints
☐ Asthma	☐ Blood Disease	☐ Breast Augmentation
☐ Cancer	☐ Chemo/Radiation	☐ Congenital Heart Defects
☐ Depression	☐ Diabetes	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ Heart Disease	☐ Heart Surgery	☐ HIV/AIDS
☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure
☐ Mental Disorder	☐ Mitral Valve Prolapse	☐ Neurological Disease
☐ Pacemaker	☐ Premed - Amoxicillin	☐ Premed - Clindamycin
☐ Premed - Other	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatoid Arthritis	☐ Seasonal Allergies	☐ Sinus Problems
☐ Sleep Apnea	☐ Stomach Problems	☐ Stent(s)
☐ Stroke	☐ Thyroid Disorder	☐ Tuberculosis
☐ Tumor	☐ Ulcers	☐ Vertigo/Dizziness
☐ Other	☐ None of the above	

If other, please list:

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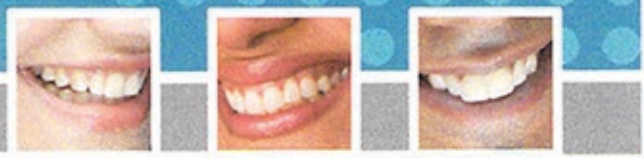

Are you currently being treated by a physician for any health concerns?

* ◯ Yes ◯ No

If yes, please explain.

Are you planning to have any medical procedures or surgeries performed in the next 6 weeks?

* ◯ Yes ◯ No

If yes: please list procedure, physician's name and date to be completed.

Has a physician or surgeon ever instructed you to take an antibiotic before dental work is performed?

* ◯ Yes ◯ No

If yes: Please list type of procedure, surgeon's name and date of surgery (or type of congenital condition).

Have you ever taken a Bisphosphonate medication? (i.e. Boniva, Actonel, Fosomax, Didronel, Reclast)

* ◯ Yes ◯ No

If yes, which medication(s) and were they administered orally or through an IV?

Do you ever have chest pain or trouble breathing?

* ◯ Yes ◯ No

Have you been hospitalized in the last 6 months?

* ◯ Yes ◯ No

If yes, please explain.

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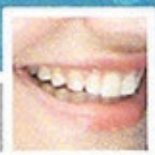
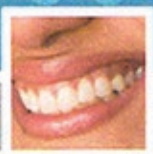
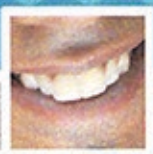

Please list any other surgeries, operations, hospitalizations or emergency room visits you have had within the last 5 years.

Do you ever use tobacco products?

* ◯ Yes ◯ No

If yes: What type, how much/how often, and how long have you used for?

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If yes, approximate due date:

Please list ALL MEDICATIONS, SUPPLEMENTS and VITAMINS you are currently taking and the REASON you are taking them. (If you are not currently taking medications, please type "None".)

*

OFFICE USE ONLY: NOTES

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FINANCIAL PRACTICES

We are dedicated to helping you keep your smile healthy and beautiful for a lifetime. We know you depend on us to explain all dental procedures and associated fees clearly and professionally before we begin treatment. We believe it is not only important to provide the highest quality dental care, but to make this care affordable for our patients. We will make arrangements for our patients which allow payments to be convenient and flexible. We are committed to helping you receive the dental care you desire and for you to have the most pleasant and comfortable dental experience possible.

To keep costs down for you, we would like to eliminate the expense of sending out bills for treament received in our office. By doing this, we can pass the savings along to you! We are proud to be able to help you save money whenever you visit us. If you want to make monthly payments, you can, through Care Credit. For more information, please contact us.

WE ASK THAT YOU PAY US FOR YOUR SERVICES ON THE DAY OF TREATMENT BY CHOOSING ONE OF OUR CONVENIENT PAYMENT OPTIONS:

A. Payment on the day of treatment with:
*Cash or Check
*Visa, MasterCard or Discover Credit or Check cards

B. We are happy to submit insurance claims for you.

C. No- or Low-interest payment plans with the flexibility and convenience of making payment(s) at a later date through Care Credit.

NOTE TO OUR PATIENTS WITH INSURANCE...ALL OF OUR PAYMENT OPTIONS HELP YOU TO USE YOUR INSURANCE IN OUR OFFICE!

*We are happy to process your insurance claim as a service to you at no charge.

*We are here to assist you in understanding the nature of your dental plan and to help you maximize your dental benefits.

*Your insurance plan is based upon a contract between your employer and the insurance company. Any dollar amount a plan reimburses for dental services is determinded by how much your employer has paid for the plan. If you have any

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questions or concerns regarding the specifics of your dental insurance plan, please contact your employer or insurance company directly. With that in mind, please be aware that any estimate our office many provide to you regarding benefits fo your plan is made in an effort to inform, not imply a guarantee of payment by your dental insurance, and that you are ultimately responsible for all treatment fees incurred.

We are proud that our fees reflect the time that the doctor spends with each patient as well as the overall quality of care and service that we provide in our practice. Our goal is to help you achieve optimum health and a healthy smile. Thank you for choosing our practice to care for you!

APPOINTMENT POLICIES

We consider the time set aside for your dental appointment to be yours alone. For this reason, we do not double-book our schedule or accept drop-ins, except in emergencies. Consequently, when you cancel your appointment, especially at the last minute, our entire practice is affected.

Not only are we committed to bringing you the very best professional and personal care that we can, we also place great value on your time. Please pay us the same respect by giving us a 48 hour advance notice when you cancel an appointment so that we can use that time for the benefit of our other patients. If we do not receive a 48 hour notice, it will be considered a failed appointment and we reserve the right to charge a missed appointment fee. Chronically missed appointments will not be tolerated. When you routinely miss appointments, your dental health suffers too.

Because we want to use our time together to the fullest, as well as respect our other patients' time, we also ask that you arrive to your appointment at the scheduled time.

We understand that cancellations are sometimes necessary, as illnesses/emergencies do occur. You will NOT be charged for an appointment that was cancelled due to an illness or emergency. If you are unable to make your appointment due to an illness, please call and let us know as soon as you can.

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NOTICE OF PRIVACY PRACTICES

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.

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.

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 (i.e. If you would need to be referred to an oral surgeon to have your wisdom teeth removed).

PAYMENT: We may use and disclose your information to obtain payment for services we provide to you (i.e. Insurance companies require certain information in order to submit your insurance claim. If we do not have access to this information or if we do not have your permission to share it with your insurance, you will need to process your own insurance.)

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations, which include quality assessments 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.

YOUR AUTHORIZATION: In addition to our use of your health information for treament, 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 authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us 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, and may disclose your health information to a family member, friend, or 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.

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PARENTAL CONSENT

If circumstances arise and I am unable to accompany my child (who is under 18 years of age) to their dental appointment, I know that it is my responsibility to make prior arrangements with Elgin Family Dentistry to give consent for treament as well as make necessary financial arrangements.

I will also provide a contact number where Dr. Kingsley and her staff can reach me during the scheduled appointment time to ensure necessary treatment recommendations, dental concerns, referrals, etc. are being communicated.

I understand that treatment recommendations may change based on conditions found during treatment. I give Dr. Kingsley permission to proceed with recommended treatment based on her professional opinion, as she deems necessary.

GENERAL TREATMENT CONSENT

I understand that any recommended treatment will be discussed prior to treatment being performed.

I also realize that treatment may change based on conditions found during treatment. I give Dr. Kingsley permission to proceed with recommended treatment based on her professional opinion, as she deems necessary. (i.e. during the placement of a filling, the decay is found to be more extensive than x-ray concluded; In this situation, depending on HOW much larger decay is, a larger filling may need to be placed or the tooth may need to have a root canal. If the tooth were to need a root canal, this would be discussed with patient prior to root canal being performed and options would also be given.)

☐ By checking this box, I acknowledge that I have read this statement and agree to the contents.

Response Date: _____

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Consent for Internet Communications

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Response Date: _____

RELEASE OF DENTAL RECORDS

Patient's name _____

Date of birth ____/____/____

Address _____

_____

_____

Telephone number (____) ____-_____

Please release my dental records from:

Name of provider _____

Provider's address _____

_____

_____

TO:

Elgin Family Dentistry

124 2nd Avenue

Elgin, MN 55932

EMAIL: elginfamilydentistry@gmail.com

I HEREBY AUTHORIZE THE RELEASE OF MY DENTAL RECORDS AS PROVIDED ABOVE.

_____ Date: _____

Patient's Signature