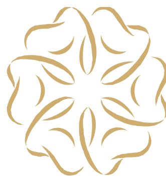


MONROE SMILES
SARI KLERER DMD

Patient Information

Date: ____________________________

Patient Name: ____ Date of Birth: ______________________

Address:__________________________________ City:____________________ State:_______ Zip: ________________

Sex: Male / Female ____Single ____ Married ____Divorced ____Widowed

Home Phone: ________________________ Cell: _______________________ Work: ________________________________

Email: ____________________________________ Preferred way of contact: Home Cell Work Email

Social Security # ____________________________ Occupation: ____

Employer Name: ____________________________ Address:____

Spouse Name: ______________________________ Occupation: ____

Spouse Employer: ___________________________ Business Phone #: ______________________________________

In case of an emergency, who should be notified? _________________________ Phone: ___________________________

Relationship: ___________________________ May we discuss treatment? ______________________________________

Whom may we thank for referring you? ____

Dental Insurance Information

Primary Insurance Company: ________________________________ Phone: _________________________________

Policy Holder: __________________________ Id #: __________________________ Group #: __________________

Policy holder date of birth: ____________________________ Relationship to patient:_________________________

Secondary Insurance Company: ___________________________ Phone: _________________________________

Policy holder: __________________________ Id #: __________________________ Group #: __________________

Policy holder date of birth: ____________________________ Relationship to patient:_________________________

I understand that I am financially responsible for all charges whether or not paid by insurance. *I certify that I, and /or my dependents(s) have insurance coverage with ___________________ and assign insurance benefits directly to Monroe Smiles, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Monroe Smiles may use my healthcare information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.*

Signature of Patient or Guardian: ___________________________________ *Date:* ___________________________

Medical History

Name: ____ Date of birth:______________________________

Correct answers to the following questions will allow the doctor to treat you on a more individual basis and provide the care appropriate for your needs. Your answers are for our records only and will be considered confidential.

Are there any **medical conditions** you are currently being treated for? __Yes __No If yes, please explain:___________

____

Allergies: **Penicillin** __Yes __ No **Latex** __Yes __No **Novocaine** __Yes __ No

Other: ____

Please check all that apply:

___ Acid reflux/GERD
___ Alzheimer's/Dementia
___ Anemia
___ Angina
___ Anxiety
___ Arthritis, Rheumatism
___ Artificial heart valve
___ Artificial joints
___ Atrial fibrillation
___ Asthma
___ Bleeding abnormally, with extractions or surgery
___ Blood disorders
___ Blood transfusions
___ Cancer
___ Chemotherapy
___ Circulatory problems
___ Congenital heart disease
___ Cortisone treatments
___ Cough, persistent or bloody
___ Defibrillator
___ Diabetes
___ Drug/Alcohol dependency
___ Dry mouth/excessive thirst
___ Emphysema
___ Epilepsy
___ Fainting or dizziness
___ Fibromyalgia
___ Gastro-intestinal problems
___ Glaucoma
___ Headaches (frequent)
___ Heart murmur
___ Heart attack
___ Heart problems
___ Hemophilia
___ Hepatitis, type______
___ Herpes
___ HIV/AIDS
___ High blood pressure
___ Jaundice
___ Jaw pain
___ Kidney problems
___ Liver problems
___ Lyme disease
___ Low blood pressure
___ Mitral valve prolapse (MVP)
___ Nervous problems
___ Osteoporosis
___ Pacemaker
___ Psychiatric care
___ Radiation treatment
___ Respiratory disease
___ Rheumatic fever
___ Seizures
___ Shortness of breath
___ Sinus trouble
___ Stroke
___ Swollen feet or ankles
___ Swollen neck glands
___ Thyroid problems
___ Tobacco habit
___ Tuberculosis
___ Ulcers
___ Weight loss, unexplained

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? __Yes __No

If yes, explain ____

****Women Only****

Are You Pregnant? __Yes __No

Are you nursing? __Yes __No

Are you taking Birth Control Pills? __Yes __ No

If yes, name: ___________________________________

Medication List

Name and Dosage	Times Per Day	Purpose

Physician's Name	Specialty	Phone Number

Do you take antibiotic prophylaxis prior to dental treatment? ___Yes ___ No
If yes, name of antibiotic: ___________________________________

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for **osteoporosis** or **Paget's Disease**? ___Yes ___No If yes, name:_______________________

Name of Pharmacy: _____________________________ Phone: ________________________

Our office requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. By signing below, you agree that all information given is accurate and that you will update this information as subsequent appointments.

Patient name (please print): ____

Patient signature: ____ Date: ________________

If minor, parent or legal guardian name: ____

If minor, parent or legal guardian name: ____

MONROE SMILES
SARI KLERER DMD

INFORMED CONSENT

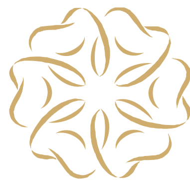
1. I, ___________________________, hereby authorize and direct the dentist, **Dr. Sari Klerer**, **DMD**, and/or dental auxiliaries of her choice to perform the following dental treatment including the use of any necessary or advisable local anesthesia, radiographs (x-rays), diagnostic aids (impressions), photographs, etc.
    - **A.** Preventive hygiene treatment (prophylaxis) and application of topical fluoride.
    - **B.** Application of plastic sealants to the grooves of the teeth
    - **C.** Treatment of diseased or injured teeth with fillings, endodontics, and/or crowns.
    - **D.** Replacement of missing teeth with dental prostheses, i.e., dentures, crowns, implants, etc.

2. I understand that there are risks involved in dental treatment and hereby acknowledge that these risks will be explained to me and that I have an opportunity to ask questions regarding the treatment and the risks so that I may understand the same.
3. I agree that the success of the treatment requires that all post-operative instructions be followed and that regular office visits as scheduled by the dentist be maintained.
4. I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from the discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary for my oral health and well-being.
5. There are possible risks and complications associated with the administration of local anesthesia. The most common of these are swelling, pain, bleeding, vomiting, bruising, and numbness of the lips, cheek and gum, allergic reactions, hematoma, fainting, lip or cheek biting resulting in the ulceration and infection of mucosa. I also understand that many prescription medications may have risks associated with them as well. I further understand that there are potentially greater risks, such as respiratory and cardiovascular collapse.

I hereby state that I have read and understand this consent and that I have the right to be provided answers to all my questions.
I also understand that I am financially responsible for all work performed by or under the direction of Dr. Sari Klerer.

Patient/Guardian signature: ______________________________________ Date: ___________________________

Witness: ____ Date: ___________________________



Dental History

Name: ______________________________________ Today's date: ____________________________________

Are there any concerns you would like to discuss today? ____

____

Previous dentist name and phone number: ____

Date of last exam/cleaning: _________________ May we request previous dental records? __Yes __No

Previous frequency of check-ups: 3 month 4 month 6 month Other______________________

- Have you ever been treated for periodontal (gum) disease? __Yes __No If yes, date: __________________
- How do you feel about your smile? ____
- Have you ever whitened your teeth? ___Yes ___No If yes, date: ______________________________
- Do you wish your teeth were whiter? ___Yes ___No
- Does dental treatment make you nervous? ___Yes ___ No __ Slightly __ Moderately __ Extremely
- How often do you brush your teeth daily? _____________________ Floss? _________________________________
- Do you have any old restorations (fillings, crowns, bridges, etc) that you don't like the appearance of?
  __Yes __No If yes, please explain: ____

Do you use any regularly? Please circle:

Mouth rinse Fluoride Rubber Tip Waterpik Electric toothbrush
Proxabrush Stimudent Soft-picks Rx Fluoride Toothpaste Chlorhexidine Rinse

Please circle all that apply:

Bad Breath
Bleeding gums
Blisters on Lips/Mouth
Burning sensation on tongue
Chew on one side of mouth
Cigarette/Pipe/Cigar Smoking
Clicking or popping of jaw
Dry mouth
Fingernail biting
Food collection between teeth
Foreign objects
Grinding teeth

Gums swollen or tender
Jaw pain or tiredness
Lip or cheek biting
Loose teeth or broken fillings
Mouth breathing
Mouth pain when brushing
Orthodontic treatment
Pain around ear
Periodontal treatment
Sensitivity to cold
Sensitivity to hot
Sensitivity to sweets

Sensitivity to biting
Sores or growths in your mouth
Nightguard
Retainers
Full Upper Denture
Full Lower Denture
Upper Partial Denture
Lower Partial Denture
Chipped teeth

MONROE SMILES
SARI KLERER DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT*****

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
(Please print name)

____
(Signature)

____
(Date)

*******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)

____
____
____