DENTAL 1

5270 Highland Rd (M-52)
Waterford, MI 48327
(248) 673-2400

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Transgender ☐ Married ☐ Single ☐ Other _____ Birth Date: _____

Social Security #: _____ Driver's License #: _____ State: _____

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

(Cell) _____ E-Mail: _____ Fax: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact: _____
First & Last name Contact Number

Primary Dental Insurance Information

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

Insured's Birth Date: _____ ID #: _____ Group #: _____ SS#: _____

Insured's Address: _____
Street City State

Insured's Employer Name: _____ Insurance Company: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Plan Name and Telephone: _____

Secondary Dental Insurance Information

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

Insured's Birth Date: _____ ID #: _____ Group #: _____ SS#: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____ Insurance Company: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Plan Name and Telephone: _____

Cosmetic Information

Is there anything about your smile that you do not like?_____

Are you interested in knowing the options available for a more beautiful smile? _____

Do you like the appearance of your teeth?_____

Are all of your teeth in alignment (straight)?_____

Do you have any missing teeth? _____ Are any chipped?_____

Is your bite comfortable when chewing, biting?_____

Do you have frequent headaches?_____

Do you have any old fillings or dental treatment that you are unhappy with?_____

What would you like to change the most about the appearance of your teeth?_____

Is there anything else that you would like us to know?_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another Doctor

☐ Dental Office ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for: ☐ Self ☐ the person responsible for payment

Name: _____

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

Social Security #: _____ Birth Date: _____ Driver's License #: _____

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

Address: _____

Street Apartment # City State Zip Code

Please list people to whom we may release your medical information to: _____

_____

HEALTH INFORMATION

Previous Dentist: _____ Date of Last Dental Visit: _____

Reason for this visit: _____

- Are you currently under a physician's care now? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had a serious head or neck injury? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medications, pills, or drugs? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No
- Are you on a special diet? ☐ Yes ☐ No
- Do you use tobacco? ☐ Yes ☐ No
- Do you use controlled substances? ☐ Yes ☐ No

Women - Are you:

Pregnant/Trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ____.

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

_ AIDS/HIV Positive	_ Diabetes	_ Hepatitis B or C	_ Rheumatic Fever
_ Alzheimer's disease	_ Drug Addiction	_ Herpes	_ Rheumatism
_ Anaphylaxis	_ Easily Winded	_ High Blood Pressure	_ Scarlet Fever
_ Anemia	_ Emphysema	_ High Cholesterol	_ Shingles
_ Angina	_ Epilepsy or Seizures	_ Hives or Rash	_ Sickel Cell Disease
_ Arthritis/Gout	_ Excessive Bleeding	_ Hypoglycemia	_ Sinus Trouble
_ Artificial Heart Valve	_ Excessive Thirst	_ Irregular Heartbeat	_ Spina Bifida
_ Artificial Joint	_ Fainting Spells/Dizziness	_ Kidney Problems	_ Stomach/Intestinal Disease
_ Asthma	_ Frequent Cough	_ Leukemia	_ Stroke
_ Blood Diseases	_ Frequent Diarrhea	_ Liver Disease	_ Swelling of Limbs
_ Blood Transfusion	_ Frequent Headaches	_ Low Blood Pressure	_ Thyroid Disease
_ Breathing Problems	_ Genital Herpes	_ Lung Disease	_ Tonsillitis
_ Bruise Easily	_ Glaucoma	_ Mitral Valve Prolapse	_ Tuberculosis
_ Cancer	_ Hay Fever	_ Osteoporosis	_ Tumors or Growths
_ Chemotherapy	_ Heart Attack/Failure	_ Pain in Jaw Joints	_ Ulcers
_ Chest Pains	_ Heart Murmur	_ Parathyroid Disease	_ Venereal Disease
_ Cold Sores/Fever Blisters	_ Heart Pace Maker	_ Psychiatric Care	_ Yellow Jaundice
_ Congenital Heart Disorder	_ Heart Trouble/Disease	_ Radiation Treatments	
_ Convulsions	_ Hemophilia	_ Recent Weight Loss	
_ Cortisone Medicine	_ Hepatitis A	_ Renal Dialysis	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes, please explain:

_____

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 doctor at the next appointment without fail.

_____ Date_____

Signature of patient, parent or guardian

_____ Date:_____

Signature of Doctor

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment 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.

Our office will prepare and submit dental insurance forms on behalf of the patient. The patient will be responsible for all estimated copays and deductibles on the date of service. After payment from the insurance company we will bill the patient for any unpaid balances.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) 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 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.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

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.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

PATIENT ACKNOWLEDGMENT 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 office 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.

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING "ACKNOWLEDGMENT" TO ACKNOWLEDGE THAT YOU HAVE TODAY RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with:

1. A defense to a claim challenging our professional competence;
2. A review entity's functions;
3. A claim for payment of fee's;
4. A third party payers examination of our records;
5. A court order as a part of a criminal investigation;
6. An identification of a dead body;
7. A licensure investigation; or
8. 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.

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.

PATIENT ACKNOWLEDGMENT

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

_____

Patient/Guardian Signature

PATIENT CONSENT

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

_____

Patient/Guardian Signature

****

Office Use Only

____ Patient Refused to Sign

____The following circumstances prohibited the patient from signing the Acknowledgment:

_____

____

____An emergency situation prevented the patient from signing the Acknowledgment.

_____ _____

Date_____

Office Personnel (signature) Office Personnel (print name)