PERSONAL PATIENT INFORMATION

Full Name: ________________________ ____________________________ Preferred Name: ______________ Today's Date: _____/_____/______
Birthdate: _____/_____/__________ SS#: ________-______-__________ Male ⑥ Female ⑥
Address: ____ City: _________________________ State: _____ Zip Code: _____________

Home Phone: ______________________________ Work Phone: ____________________________ Cell Phone: _______________________

E-mail Address: _______________________________________ Employer or School/College: ____

Parent or Guardian's Name: _____________________________________ Relationship to Patient: _____________________________________

Person to contact in case of an emergency: ____ Phone: ________________________________

Referred by: (ex: Patient name/online/ insurance) ___________________________________

Name of Previous Dentist: ____ Date of Last Exam: ________________________________

MEDICAL HISTORY

Are you allergic to or have you had reactions to the following:
PLEASE CHECK ALL THAT APPLY:

☐ Local anesthetics like Novocaine?
☐ Penicillin?
☐ Other Antibiotics? **Please list:**__________________________
☐ Sulfa Drugs?
☐ Barbiturates? ☐ Sedatives? ☐ Sleeping pills?
☐ Aspirin?
☐ Iodine?
☐ Other? **Please list:**_________________________________

General Health questions:

YES NO

☐ ☐ Are you in good health?
☐ ☐ Have there been any changes in your general health within the past year?
☐ ☐ Are you now under the care of a physician?
Date of your last physical exam: ________/_______/_____________

Physician's Name: ___________________________________
Phone Number: ______________________________________

☐ ☐ Have you ever been hospitalized for any surgical operation or serious
Illness? **Please explain:** ________________________________
☐ ☐ Are you taking any medicine(s) including non-prescription medicine?
Please list: ____
☐ ☐ Are you taking Fosamax or Boniva?
☐ ☐ Are you on Blood Thinners? **Please list:**
____
☐ ☐ Do you require **antibiotic pre-medication** before dental appointments?
☐ ☐ Have you had any abnormal bleeding?
☐ ☐ Do you bruise easily?
☐ ☐ Have you ever required a blood transfusion?
☐ ☐ Have you had a recent weight loss?
☐ ☐ Do you use tobacco?
☐ ☐ Do you use alcohol?
☐ ☐ Do you use cocaine or other drugs? **Please list:**_________________
Height: ___________________ Weight: ___________________
☐ ☐ Do you bite your lips or cheeks frequently?
☐ ☐ Have you had any head, neck or jaw injuries?
☐ ☐ Have you experienced any of the following problems in

Do you currently have or have you ever had the following: PLEASE CHECK ALL THAT APPLY

☐ Rheumatic heart disease or rheumatic fever?
☐ Scarlet Fever?
☐ Heart trouble:
☐ Heart attack? ☐ Angina? Murmur?
☐ Do you get short of breath when you lie down?
☐ Heart surgery?
☐ Bypass ☐ Pacemaker ☐ Stent placed
Date:_______
☐ High Blood Pressure?
☐ Low Blood Pressure?
☐ Hepatitis? Type: ______
☐ Jaundice? ☐ Liver disease?
☐ Stroke?
☐ Sinus trouble?
☐ Lung or breathing problems?
☐ Asthma ☐ COPD ☐ Emphysema ☐ Sleep Apnea
☐ Diabetes?
☐ Diet controlled or ☐ Insulin Dependent
☐ AIDS? ☐ HIV?
☐ Thyroid problems?
☐ Seasonal allergies? ☐ Hives? ☐ Skin rash?
☐ Arthritis ☐ Rheumatism
☐ Joint replacement? ☐ Implant?- **Date:**________
☐ Stomach ulcer?
☐ Kidney trouble?
☐ Tuberculosis?
☐ Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?
☐ Cough that produces blood?
☐ Cancer?
☐ Sexually transmitted disease?
☐ Epilepsy? ☐ Seizures? ☐ Fainting spells?
☐ Multiple Sclerosis?
☐ Anemia?
☐ Leukemia?
☐ Glaucoma?
☐ Frequent headaches?
☐ Prolonged bleeding?
☐ Do you have any other disease /condition not listed previously? **Please List:**___________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X____ X_________________________
SIGNATURE OF PATIENT /PARENT/GUARDIAN DATE

____ _________________________
DR. SIGNATURE DATE

FINANCIAL POLICY

Who is responsible for payment of the account? This is an agreement between **Dental 1**, as creditor, and the Patient/Debtor named on this form.

Name: ______________________________ Relationship to patient: ______________ Signature: ______________________

Address: ______________________________ City: ______________________________ State: _______ Zip Code: ___________

SS#: ________________________ Birthdate: _______/________/________ Driver's License#: ___________________________

Phone: ________________________

Payment Options:

1. **Payment is due the day service is rendered**.
2. We offer special financing through Care Credit. Care Credit offers no interest and extended payment plan options.

Insurance: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You agree to pay any portion of the charges not covered by insurance.**

Returned Checks: There is a $25 returned check fee. If the check and the returned check fee are not paid in full within ten days, the check may be turned over to the Oakland County Prosecuting Attorney for criminal action.

Missed Appointment Fee: The third time a patient does not show up for an appointment, or cancels with less than **48** hours notice, a $50 fee will be charged. This fee must be paid before a new appointment is scheduled.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency/lawyer, you agree to pay all of the collection costs/lawyer costs which are incurred. In case of suit, you agree the venue shall be in Oakland County, Michigan. We charge a monthly fee for every month past due.

Waiver of Confidentiality: If your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Workers Compensation / Personal Injury: We require written approval/authorization by your employer, worker's compensation carrier or and/or attorney prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

HIPPA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR DENTAL 1

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, and healthcare operations.
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 is available to you to read in our office or take home with you.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices.
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 on the privacy forms. 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.

I, ______________________________, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I, ______________________________, do hereby grant permission for Dental 1 dentists and/or staff members to disclose my personal health information to the following personal representative(s):
(spouse, sibling, parent, child, friend, etc.). PLEASE WRITE NONE IF YOU DO NOT WANT ANY INFORMATION GIVEN TO ANYONE.

- ____

Signature:______________________________________ Date: __________________

EMAILING X-RAYS

I understand that x-rays might need to be emailed to other specialists and insurance companies. I give permission for this.
Signature:______________________________________ Date:__________________