PATIENT REGISTRATION INFORMATION:

PATIENT INFORMATION:	
Full Name:	**Preferred Name:**
Date of Birth:	**Cellular:**
Email Address:	**Home/Work/Other Phone:**
Address:	**City/State/Zip:**

RESPONSIBLE PARTY (if someone other than the patient)**:**	
Full name:	**Date of Birth:**
Cellular:	**Home/Work/Other Phone:**
Address:	**City/State/Zip:**
Email Address:	

EMPLOYMENT/STUDENT INFORMATION:	
Employment Status: *(please circle one)*	**FULL TIME / PART TIME / RETIRED**
Student Status: *(please circle one)*	**FULL TIME / PART TIME / K-12**

PREFERRED PHARMACY:	
Name of Pharmacy:	**Contact Number:**

PRIMARY INSURANCE INFORMATION:	
Name of Insured:	**Insured Birth Date:**
Patient relationship to Insured: (please circle one) **SELF / SPOUSE / CHILD / OTHER:**	**Insured Social Security Number: _____** **Insured Identification Number: _____**
Insurance Company:	**Employer:**

SECONDARY INSURANCE INFORMATION:	
Name of Insured:	**Insured Birth Date:**
Patient relationship to Insured: (please circle one) **SELF / SPOUSE / CHILD / OTHER:**	**Insured Social Security Number: _____** **Insured Identification Number: _____**
Insurance Company:	**Employer:**

Medical History

Patient Name: **Birth Date:** ___ / ___ / _____

Are you under a physician's care now?	◯ Yes ◯ No	If yes, _____
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes, _____
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes, _____
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes, _____
Do you require antibiotics (Premedication) for any dental appointments? If so, what is the reason and medication?	◯ Yes ◯ No	If yes, _____
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes, _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes, _____
Are you on a special diet?	◯ Yes ◯ No	If yes, _____
Do you use tobacco?	◯ Yes ◯ No	If yes, _____
Do you use controlled substances?	◯ Yes ◯ No	If yes, _____

Women: Are you…

◯ Pregnant/Trying to get pregnant? ◯ Nursing? ◯ Taking oral contraceptives?

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa Drugs

◯ Local Anesthetics ◯ Other? If yes, _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsilitis ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Other serious illness? ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	If yes, _____
Cortisone Medicine ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No	

Comments:

Signature of Parent, Patient, or Guardian

X_____ **Date: ___ / ___ / _____**

DENTAL HISTORY

NAME:	**AGE:**
Name of previous Dentist:	**How long have you been a patient at your previous Dental Office: _____** *(months/years)*
Date of most recent dental exam: ___ /___ /_____	**Date of most recent treatment: ___ /____ /____** *(other than a cleaning)*
How would you rate the condition of your mouth? *Please circle one*- EXCELLENT / GOOD / FAIR / POOR	**I routinely see my dentist every:** *Please circle one*- 3 months / 4 months 6 months / 12 months Not Routinely
What is your immediate concern? _____	

PERSONAL HISTORY	**YES**	**NO**
Are you fearful of dental treatment? How fearful on a scale of 1(least)-10(most):		
Have you had an unfavorable dental experience? Explain:		
Have you ever had complications from past dental treatment? Explain:		
Have you ever had trouble getting numb/had any reactions to local anesthetic? Explain:		
Did you ever have braces, orthodontic treatment, or had your bite adjusted? If YES, what age and what type of treatment:		
Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? Explain:		
Do your gums bleed or are they painful when brushing or flossing?		
Have you ever been treated for gum disease or been told you have lost bone around your teeth?		
Have you ever noticed an unpleasant taste or odor in your mouth?		
Is there anyone with a history of periodontal disease in your family? Explain:		
Have you ever experienced gum recession?		
Have you had any cavities within the past 3 years?		
Does the amount of saliva in your mouth seem too little/do you have difficulty swallowing any food?		
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? Explain:		
Do you have grooves or notches on your teeth near the gum line?		
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? Explain:		
Do you frequently get food caught between any teeth?		
Do you have problems with your jaw joint? (pain/sounds/limited opening/locking/popping) Explain:		
Do you avoid or have difficulty chewing hard, dry foods? Explain:		
Are your teeth becoming more crowded/crooked/overlapped? Explain:		
Are your teeth developing spaces or becoming looser?		
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		
Do you clench or grind your teeth together in the daytime or make them sore?		
Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?		
Do you wear or have you ever worn a bite appliance?		
Is there anything about the appearance of your teeth that you would like to change? (shape/color/size)		
Have you every whitened (bleached) your teeth? Explain:		

X_____ Date: ___ /___ /_____

Patient Signature

Medical Information Release Form

Name: _____ Date of Birth: ___ /___ /____

Please read the options below:

Place a ✓ in the first box if you would like your medical information to be released.

(please list the name of the spouse/child(ren)/other person in the line next to the options below)

OR

place a ✓ in the second box if you would not like your information released.

☐ **I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:**

-Spouse: _____

-Child(ren): _____

-Other: _____

☐ **<u>Information is not to be released to anyone.</u>**

Patient Signature: _____

Witness: _____ Date: ___ /___ /____

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree that the use of anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor or designated staffs' use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made PRIOR to your appointment. In the event payments are not received by agreed upon dates, I understand that a 1.5-2% late charge (18% APR) may be added to my account.

6. Cell Phone: I consent the dental practice using my cell phone number to call/text me regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

7. I understand that a charge up to $100 dollars may occur for missed appointments without a 48-hour notice.

Patients Signature _____ Date_____

Parent/Responsible Party Signature_____

Relationship to patient_____

Patient Acknowledgement of HIPAA

Effective April 14th, 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 our patient's information that we have collected and will collect in the future.

To comply with one of the HIPAA requirements, we have and you are welcome to a copy of our **NOTICE OF PRIVACY PRACTICES**. This Notice contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgements, discussed above) us to first obtain our patients written consent prior to disclosing any of their information except for our disclosures in connection with; a defense claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or 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 consult with another dentist or health professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating their treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgment" to acknowledge that today you have been offered a copy of our **NOTICE OF PRIVACY PRACTICES**.

I acknowledge that today I have received a copy, or been offered and declined a copy of the NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient or Parent/Guardian signature (signature) **Patient Name (print)**

_____

Date