W E L C O M E

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name ______________________________ Soc. Ser # ______________
Last Name First Name Initial

Address ______________________________

City ______________ State ______ Zip ______ Home Phone

Cell Phone ______________ Email ______________

Sex ☐ M ☐ F Age ______ Birthdate ______ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By ______________ Occupation ______________

Business Address ______________ Business Phone ______________

Business Email ______________

Whom may we thank for referring you? ______________

Notify in case of emergency ______________ Home Phone ______________

Cell Phone ______________ Business Phone ______________

Email ______________

PRIMARY INSURANCE

Person Responsible for Account ______________________________
Last Name First Name Initial

Relation to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address (if different from patient) ______________ Home Phone ______________

City ______________ State ______________ Zip ______________

Cell Phone ______________ Email ______________

Person Responsible Employed By ______________ Occupation ______________

Business Address ______________ Business Phone ______________

Business Email ______________

Insurance Company ______________ Phone ______________

Insurance Email ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Name of other departments under this plan ______________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________ Relation to Patient ______________ Birthdate ______________

Address (if different from patient) ______________ Soc. Sec. # ______________

City ______________ State ______ Zip ______________ Home Phone ______________

Cell Phone ______________ Email ______________

Subscriber employed by ______________ Business Phone ______________

Business email ______________

Insurance Company ______________ Phone ______________

Insurance email ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Name of other departments under this plan ______________

DENTAL HISTORY

What would you like us to do today? ______________________ Are you in dental discomfort today? __________

Former Dentist ______________________ Address ______________________

Dentist's email ______________________ Phone ______________________

Date of last dental care ______________________ Date of last x-rays ______________________

Check (√) yes or no if you have had problems with any of the following:

☐ Yes ☐ No	Bad Breath	☐ Yes ☐ No	Food Collecting between teeth	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No	Sensitivity to sweets
☐ Yes ☐ No	Bleeding Gums	☐ Yes ☐ No	Grinding or clenching teeth	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No	Sensitivity when biting
☐ Yes ☐ No	Clicking or Popping Jaw	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No	Sensitivity to hot	☐ Yes ☐ No	Sores or growths in mouth

How often do you brush? ______________________ Floss? __________

How do you feel about the appearance of your teeth? ______________________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Other information about your dental health or previous treatment ______________________

MEDICAL HISTORY

Physician's Name ______________________ Phone __________

Date of last visit __________ Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe ______________________

Are you currently under a physician's care? ☐ Yes ☐ No If yes, describe ______________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give appointment dates ______________________

Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Have you ever used a bisphosphonate medication? Brand names include Fosamax,Actonel, Atelvia, Didronel and Boniva. ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (√) yes or no if you have had any of the following:

☐ Yes ☐ No	Aids/HIV Positive	☐ Yes ☐ No	Cough, persistent	☐ Yes ☐ No	Jaw pain	☐ Yes ☐ No	Singles
☐ Yes ☐ No	Anaphylaxis	☐ Yes ☐ No	Cough Up Blood	☐ Yes ☐ No	Kidney disease or malfunction	☐ Yes ☐ No	Shortness of breath
						☐ Yes ☐ No	Skin Rash
☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Spina Bifida
☐ Yes ☐ No	Arthritis, Rheumatism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Material allergies (latex, wool, metal, chemicals	☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Artificial heart valves	☐ Yes ☐ No	Fainting			☐ Yes ☐ No	Surgical Implant
☐ Yes ☐ No	Artificial joints	☐ Yes ☐ No	Food Allergies			☐ Yes ☐ No	Swelling of feet or ankles
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mitral valve prolapse		
☐ Yes ☐ No	Atropic (Allergy prone)	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Nervous problems	☐ Yes ☐ No	Thyroid disease or malfunction
☐ Yes ☐ No	Back problems	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Pacemaker/ Heart Surgery		
☐ Yes ☐ No	Blood disease	☐ Yes ☐ No	Heart problems			☐ Yes ☐ No	Tobacco Habit
☐ Yes ☐ No	Cancer	Describe	__________	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No	Tonsillitis
☐ Yes ☐ No	Chemical dependency	☐ Yes ☐ No	Hemophilia/ Abnormal Bleeding	☐ Yes ☐ No	Rapid weight gain or loss	☐ Yes ☐ No	Tuberculosis
☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Ulcer/Colitis
☐ Yes ☐ No	Circulatory problems	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Respiratory disease	☐ Yes ☐ No	Venereal Disease
☐ Yes ☐ No	Cortisone treatments	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Rheumatic/Scarlet fever		

Is patient currently taking any medications? If yes, list all: ______________________

Does patient have drug allergies? ______________________

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status,! will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________ Date __________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

ROBERT J. STRATHMANN
2107 N. Aurelius Road
Holt, Michigan 48842
(517) 694-7610

Dear Patient:

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception- dental insurance was not designed to pay for all dental care. Most contracts have limits and or various degrees of co-payment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

We hope this information has been helpful. Please take time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance. This also will serve as a " Signature on File" for insurance billing purposes allowing the release of medical information requesting direct payment from the insurance company.

If this office accepts your insurance, I understand that I am responsible for payment of services rendered and responsible for paying and co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis, and records of treatment or examination rendered, to my insurance company.

Signature ______________________________ Date ________________

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite!

Ii is om desire to communicate to you dial vve are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously.

We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed?
Why a privacy policy now?
Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information.

This has challenged us to review not only how your health information is used within our computers hut also with the Internet, phone, faxes, copy machines, and charts.

We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies anti procedures which we developed to make sure your health information will not be shared with anyone who does not require it.

Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your **HEALTH INFORMATION** only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless wc have asked for and been voluntarily given your written permission.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization.

You may revoke that authorization in writing at any time.

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed.

We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You. have the right, to read, review, and copy your health information, including your complete chart, x-rays and billing records. If yon would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations.

Our documentation procedures will enable us to provide information on health information usage from April 14. 2003 and forward. Please let us know in writing the time period for which you are interested.

Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail, or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.