

Welcome

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. Sec. # _____
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 Address _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____
Pharmacy _____ Phone _____

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 Address _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Please complete both sides.

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:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |
- How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____
 Do you wish your teeth were straighter? Y N Do you wish your teeth were whiter? Y N
 Are you unhappy with any fillings, crowns or bridges? _____
 Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N
 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? Y N
 If yes, describe _____
 Are you currently under physician care? Y N If yes, describe _____
 Have you ever had a blood transfusion? Y N If yes, give approximate dates _____
 Have you ever taken Fen-Phen/Redux? Y N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. Y N
 Do you smoke or use other tobacco/smokeless products? Y N Please circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other _____
 Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) yes or no whether you have had any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | | |

Are you currently taking any medications? If yes, list all: _____ Do you have any drug allergies? If yes, list all: _____

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, I 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.

Dearborn West Dental
Patient Insurance/Payment Responsibility Form

We are pleased to assist you with your Dental Insurance. If you have Dental Insurance, please be aware that insurance quotes are an ESTIMATE ONLY. Coverage may be different if your deductible has not been met, annual maximum has been met, if your coverage table is lower than average insurance benefits, if your policy has been terminated or waiting periods apply.

CO-PAYS:

I understand that I am responsible to pay all Co-Pays at the time of service, prior to leaving.

DEDUCTIBLES:

If my insurance determines that I have not met my deductible I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider.

I acknowledge that I assume full responsibility for services rendered to me if my insurance carrier denies or does not cover my claim for these services. I understand the terms of the form and accept financial responsibility with or without the use of insurance coverage.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE

Due to many changes in Insurance Policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

Failing to comply could result in you being responsible for all costs incurred. Please remember your insurance policy is between you and your insurance company and not between the insurance company and your Doctor.

Patient Signature: _____

Date: _____

DEARBORN WEST DENTAL

Patient Cancellation and No Show Policy

Our Dental Team is pleased to have the opportunity to treat you. With all of our Dentists practicing together, we can offer a wide array of dental services at one convenient location. We are committed to providing you and your family with the highest quality of dental care in a caring and gentle manner.

Because we make every effort to schedule appointments that are most convenient and reserved especially for you, we ask for your commitment to keep your appointments and to please be on time. While we certainly realize that events occur which can prevent a patient from keeping their reserved appointment date, we ask that you please contact our office 48 hours prior to your appointment if any changes are necessary.

We reserve the right to charge for canceled appointments when 48 hours is not given. We do charge a \$33.00 fee for No Call/No Show appointments. In case of emergency, a No Call/No Show fee can be waived if the appointment is rescheduled and treatment is completed within one month.

I have been informed of Dearborn West Dental's Cancellation and No Show Policy, I am aware a fee may be assessed for failure to keep scheduled appointments.

Patient Signature: _____

Date: _____

**HIPAA OMNIBUS RULE
 PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
 AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

 Please print name of Patient

 Please sign Patient / Guardian of Patient

 Legal Representative / Guardian

 Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

- First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Healthcare Facility via:

- | | |
|--|--|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email | |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment _____
- I could not communicate with the patient _____
- The patient refused to sign _____
- The patient was unable to sign because _____
- Other (please describe) _____

 Signature of Privacy Officer