Michigan Gum Docs

Patient Registration Information Form

Date: _____ Driver's License # _____

Patient Name _____ M ____ F ____ Birth Date _____ Age _____

Parent and or Guardian Name _____

Address _____ City _____ Zip Code _____

Home Phone Number _____ Work Phone Number _____(ext) _____

Cell Phone Number _____ E-Mail Address _____

Social Security Number _____ ❑ Minor ❑ Single ❑ Married ❑ Widowed

Employed By: _____Occupation_____

Spouse Name: _____Spouse Birth Date_____

Spouse Employed By: _____Occupation_____

Spouse Social Security Number: _____

Person to contact in emergency _____ Phone _____

Do you have Dental Insurance? Yes No Does your Spouse? Yes No

Name or your dental carrier? _____ Name of Spouse dental carrier? _____

Name or your Primary Care Physician: _____Physician Phone Number: _____

Physician Address: _____

How Did You Find Out About Our Office: (Circle Number)

1. Referred By Patient. Who _____ **2.** Newspaper. Which?_____

3. Office Sign **4.** Internet **5.** Yellow Pages. Which One? _____

6. Referred by one of our employees. Who? _____ **7.** Other Source? _____

If Student, Name of School/College - Full or Part Time (circle one) _____

METHOD OF PAYMENT

Please check on of the following:

_____ Payment in full at each appointment

_____ Co-payment in full at each appointment

_____ Credit Card

_____ Debit Card

Patient Signature_____
(Parent or Guardian)

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Dental History

Last Dental Visit was on _____ Reason _____

Were x-rays taken? Yes No

Previous Dentist _____ Phone Number _____

Why did you leave your last dental practice? _____

How do you react to Dental Care? Dread it _____ Worry about it _____ Don't mind it _____

By asking these questions we will be able to better understand your previous dental experiences, your dental concerns and dental goals, short term and long term.

Please, help us understand your daily oral hygiene care, please check appropriate boxes

❑ Manual Tooth Brush	❑ Electric Tooth Brush	❑ Floss	❑ Floss Threader
❑ Proxabrush	❑ Waterpik	❑ Rubber Tip	❑ Stimudents
❑ Fluoride gel / rinses	❑ Mouth Wash	❑ Tongue Scraper	❑ Other

How often do you brush? ❑ 1x daily ❑2x daily ❑3x daily

YES	NO	Please check appropriate box:
❑	❑	Are you experiencing pain or discomfort from your mouth at this time? If so, where? Lower Right Lower Left Upper Right Upper Left
❑	❑	Are there any areas in your mouth that are sensitive to hot/cold/sweet? If so, where? Lower Right Lower Left Upper Right Upper Left
❑	❑	On a scale from one to ten how would you rate your smile (ten is the best) 1 2 3 4 5 6 7 8 9 10
❑	❑	Would you like to know about the different types of cosmetic options available to you in dentistry?
❑	❑	Have you noticed any loose teeth or change in your bite?
❑	❑	Have you noticed any soreness or tenderness on your gum tissue at times?
❑	❑	Do you ever notice any bleeding of your gum tissue when you are brushing your teeth?
❑	❑	Do you experience a bad taste in your mouth during the daytime hours?
❑	❑	Are you aware of any lumps in your mouth?
❑	❑	Do you find yourself avoiding some foods because they may get caught between your teeth?
❑	❑	Do you clench or grind your teeth in the daytime or night?
❑	❑	Do your jaws feel tired after eating? After you wake up in the morning? YES NO
❑	❑	Do you ever hear popping or clicking sounds when you chew? If so, where? _____
❑	❑	Have you had a night guard made for you?
❑	❑	Do you wear partials or dentures? If so, how old are they? _____
❑	❑	Have you ever had prolonged bleeding following extractions in the past?
❑	❑	Would you be interested in having straighter teeth without involving orthodontics/braces?

If there are any concerns not listed above, let us know below: _____

_____

_____

_____

_____

Michigan Gum Docs

Medical History

Are you under the care of a physician? _____ If yes, Condition _____

When was your last physical examination? _____

Have you been hospitalized or had a serious illnes within the last five years? _____ If yes, what was the problem? _____

_____

Have you been advised by a physician to pre-medicate with an antibiotic prior to having dentistry? Yes No

Physician _____ Phone _____

List of current medication **Reasons**

_____

_____

_____

_____

Are you allergic to, or have had any unusual reactions to any of the following:

Yes	No		Yes	No		Yes	No	
❑	❑	Dental Anesthetic	❑	❑	Metronidazole	❑	❑	Aspirin
❑	❑	Penicillin	❑	❑	Codeine	❑	❑	Latex
❑	❑	Erythromycin	❑	❑	Sulfa Drugs	❑	❑	Other

Do you Have or have you ever had any of the following? (Please check appropriate conditions)

Yes	No		Yes	No		Yes	No	
❑	❑	Heart Trouble/ Disease	❑	❑	Kidney Disease	❑	❑	Hypoglycemia
❑	❑	Heart Attack/ Failure	❑	❑	Arthritis/ Gout	❑	❑	Artificial Joints/Pins/ Plates
❑	❑	Irregular Heart Beat	❑	❑	Rheumatism			
❑	❑	Angina/Chest Pain	❑	❑	Thyroid Disease	❑	❑	Dental Implants
❑	❑	Congenital Heart Disorder	❑	❑	Epilepsy/ Seizures	❑	❑	Bruise Easily
❑	❑	Mitral Valve Prolapse	❑	❑	Glaucoma	❑	❑	Venereal Disease
❑	❑	Heart Murmur	❑	❑	Tumors/ Growths	❑	❑	Aids/HIV
❑	❑	Artificial Heart Valves	❑	❑	Hepatitis A Infectious	❑	❑	Ulcers
❑	❑	Rheumatic Fever	❑	❑	Hepatitis B Infectious	❑	❑	Radiation Therapy
❑	❑	Scarlet Fever	❑	❑	Hepatitis C	❑	❑	Cortisone/Hormonal therapy
❑	❑	High Blood Pressure	❑	❑	Hepatitis D			
❑	❑	Low Blood Pressure	❑	❑	Hepatitis E	❑	❑	Do you smoke? ____per day
❑	❑	Stroke	❑	❑	Liver Disease			
❑	❑	Tuberculosis	❑	❑	Jaundice	❑	❑	Do you use smokeless tobacco?
❑	❑	Sickle Cell Disease	❑	❑	Diabetes			
❑	❑	Hemophilia (Bleeding Problem)		❑	Controlled	❑	❑	Use presciption diet pills
❑	❑	Anemia		❑	Uncontrolled	❑	❑	Alcohol Abuse
❑	❑	Emphysema	❑	❑	Insulin Dependent	❑	❑	Drug Addiction
❑	❑	Asthma	❑	❑	Osteoporosis	❑	❑	Psychiatric Care
			❑	❑	Cancer	❑	❑	Nervousness
			❑	❑	Chemo Therapy	❑	❑	Alzheimer's Diseas
			❑	❑	Have you taken Zometa	❑	❑	Night Sweats

Do you have any disease, conditions or other problems I should know about, not listed above?

_____

Women Only Are you Pregnant? _____ If so, how many months? _____ Due Date _____

To the best of my knowledge, all the proceeding answers are correct. If I have any changes in my heath status or if my medicines change, I shall inform the dentist and staff at the next appointment.

_____ Date: _____

Patient Signature (Parent or Guardian)

FOR OFFICE USE ONLY

Hard and Soft Tissue Oral Cancer Exam

Normal _____ **Abnormal** _____ **If abnormal, give description** _____

_____

Dentist Signature Date Hygienist Signature Date

HIPPA Form Signed _____

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PATIENT PAYMENT POLICY

Patients who are covered under an insurance policy are responsible for anything that their insurance does not cover. Insurance estimates are provided as a courtesy. In the event that your insurance carrier pays less than the estimate, you are responsible for the unpaid balance. Estimates we provide are based on the information that your insurance company has provided to us. All payments are due at time of service & all unpaid balances are subject to late charges. Payment for these services can be made by cash, check, and/or credit/debit card. If patients need to make payment arrangements for their portion they must speak to the treatment coordinator prior to the rendering of ANY services.

PAYMENT ARRANGEMENTS

For patient portions exceeding $300 patients may contact Care Credit for up to12 months of interest free financing. This service must be applied for PRIOR to services. Please ask our front office for an information booklet if you are interested in this type of financing. For patient portions less than $300 patients may leave a credit/debit card on file with the business office and the portion may be split over two or three months. If this option is selected, a credit/debit card MUST be left on file. Services will automatically be charged to this card one time per month on the agreed upon date for the agreed upon amount. If the credit/debit card is declined a $25 fee will be applied to the patient's account and the patient will be contacted immediately. If for any reason the patient does not make payment within 30 days of the credit/debit card being declined the account will automatically be sent to collections. Patients who have a balance less than $300 may also apply for Care Credit for 6 months of interest free financing.

RETURNED CHECK POLICY

There will be a $25 charge for all returned checks. Patients are also responsible for any bank charges that may be assessed. Payment for the returned check must be made with cash, money order, or cashier's check.

COLLECTION AGENCY POLICY

Services rendered must be paid within 30 days from the date of service unless financial arrangements are made PRIOR to services. (See above for payment arrangements.) This is regardless of insurance paying their estimated portion. If the account is delinquent for 90 days, a letter will be sent to the patient notifying them of our decision to send the account to collections. The patient will then have 10 days to make payment in full on the delinquent account or it will be sent to collections immediately. If the account goes to collections the patient is responsible for any fees incurred.

FAILED/SHORT-NOTICE CANCELLATION POLICY

Michigan Gum Docs requires 48 hours notice to either cancel or change an appointment. If you are scheduled for a surgical procedure we require 72 hours notice to cancel or change the appointment. If proper notice is not given on the first offense, the patient will be provided with a verbal warning. On the second offense, the patient will be charged a non-refundable $50 per hour fee.

I have read and understand the financial policy, and agree to honor the policy.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

18860 W. Ten Mile Road, Suite 2
Southfield, Michigan 48075

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

NAME OF PATIENT (***PLEASE PRINT***)

SIGNATURE OF PATIENT DATE

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

BELOW THIS LINE FOR OFFICE ONLY

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY

SIGNATURE

TITLE DATE