

Please complete the following Information:

PATIENT REGISTRATION

Patient Name:		INSURANCE INFORMATION	
Address:		Insurance Co.:	
City:	State:	Zip	Employer:
Home Phone:	Work Phone:		Employee: Birth Date:
Birth Date:	Social Security No.:		Employee Address:
Employer:	Years Employed		Employee Social Security No.:
Marital Status S M Div Wid	Spouse Name		Group No.: Union/Local No.:
<input type="checkbox"/> Male <input type="checkbox"/> Female	How did you find out about our office?		If you have another insurance plan, please complete the following:
This Form is being completed by: <input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other (Please explain)			Insurance Co.:
			Employer:
			Employee: Birth Date:
Patients under the age of 18 cannot be treated unless accompanied by a parent or legal guardian.	Closest Relative not living with you:		Employee Address:
	Name: _____		Employee Social Security No.:
	Phone: _____		Group No.: Union/Local No.:

Person financially responsible for account/relationship to patient.	BIRTHDATE OF PERSON FINANCIALLY RESPONSIBLE _____
Name: _____	Relationship _____

* If you are using Dental Insurance*

Account charge is based on your *estimated* co-payment. We will then bill your Insurance Company for the estimated insurance portion. If the Insurance Company pays less than expected, you will be billed for the difference. If the Insurance Company pays more than expected, your account will be credited. If a refund is due, you must call the office and request it. We do not guarantee Insurance eligibility. Whatever portion your Insurance Company does not pay is your responsibility.

Authorization To Release Information:

I hereby certify that I have or will review the Plan Of Treatment and the Fee to be charged. I authorize the release of any information related to these services. I understand that the dentist will estimate my co-payment (if any) and bill my Insurance Company (if applicable). I understand that I am financially responsible for this account. I am responsible for any/all collection and/or attorney fees should I fail to meet my financial responsibilities for services rendered.

Patient Signature: X _____ Date: _____
 (Parent or Legal Guardian)

Authorization to pay benefits to Dentist:

I hereby authorize payment directly to the Dentist of the benefits otherwise payable to me for services rendered. This authorization may be kept on file to be used for this dentist.

Patient Signature: X _____ Date: _____

Doctor History Review

1. _____ / _____
 INITIALS DATE

2. _____ / _____
 INITIALS DATE

Consultation

1. Pt. CC. _____

2. Quote _____

3. Advised FMX,IOE _____ YES NO

DOCTOR'S SIGNATURE _____ / _____
 DATE

ALERT

MEDICAL HISTORY

1. General Health Excellent Good Fair Poor

2. Are you under the care of a medical doctor at present? YES NO
If yes, for what? _____

3. What is your medical doctor's name (clinic or Hospital name) _____
Address: _____ Phone No.: _____

4. Are you taking medication now YES NO
If yes, what medication? _____

5. Are you allergic to or have you had any reaction to any medication YES NO
If yes, which medication? _____

6. Have you had a reaction to penicillin, erythromycin, codeine, aspirin, or local anesthetics? YES NO

7. Indicate which of the following you have had or have now. Circle YES or NO.

Heart Disease/Attack	YES	NO	Anemia	YES	NO	A.I.D.S.	YES	NO
Heart Surgery	YES	NO	Ulcers	YES	NO	H.I.V. Positive	YES	NO
Congenital Heart Disease	YES	NO	Emphysema	YES	NO	Venereal Disease	YES	NO
Heart Murmur	YES	NO	Diabetes	YES	NO	Cold Sores	YES	NO
High Blood Pressure	YES	NO	Thyroid Problem	YES	NO	Blood Transfusion	YES	NO
Rheumatic Fever	YES	NO	Glaucoma	YES	NO	Hemophilia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Herpes	YES	NO
Artificial Heart Valve	YES	NO	Cough	YES	NO	Epilepsy or Seizures	YES	NO
Artificial Joint	YES	NO	Asthma	YES	NO	Nervous Condition	YES	NO
Mitral Valve Prolapse	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Hip Replacement	YES	NO	Sinus Trouble	YES	NO	Yellow Jaundice	YES	NO
Dialysis Treatment	YES	NO	Cortisone Medication	YES	NO	Fainting, Dizzy Spells	YES	NO
Organ Transplant	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO
Bacterial Endocarditis	YES	NO	Tumors	YES	NO	Sickle Cell Disease	YES	NO
Stroke	YES	NO	Latex Sensitivity	YES	NO	Drug Addiction	YES	NO
Angina (chest pain)	YES	NO	Hepatitis A (Infectious)	YES	NO			
Scarlet Fever	YES	NO	Hepatitis B (Serum)	YES	NO			

8. Do you have any other disease, medical condition or problem not listed? YES NO
If yes, please list _____

9. **Women: Are you pregnant?** YES NO If yes, when are you due _____

Are you breastfeeding? YES NO

Are you taking birth control pills? YES NO

(antibiotics may decrease effectiveness of birth control pills or norplant, check with your doctor.)

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the dentist at the next visit without fail.

DATE

X _____
PATIENT'S SIGNATURE (Parent or legal guardian if minor)

DENTAL HISTORY

1. What is the reason for your visit today? _____

2. Date of last Dental visit? _____
Date of last full mouth Xray? _____
Date of last teeth cleaning? _____
3. Name of your last dentist? _____
4. Do you see a dentist regularly for examinations and cleaning? YES NO
Do you use floss? YES NO
5. Are you currently undergoing treatment with another dentist? YES NO
if yes, for what? _____
6. Are you having pain from your mouth now? YES NO
Do your gums bleed? YES NO
Have you been advised you have gum disease YES NO
7. Do you have, or have you ever had:
- Clicking, popping of jaw? YES NO
Pain in joint, ear, side of face? YES NO
Difficulty in opening or closing your mouth? YES NO
A bite splint or mouth guard? YES NO
Injury to mouth or head? YES NO
If yes, describe. _____
- Your bite adjusted by dentist? YES NO
8. Do you clench or grind your teeth? YES NO
9. Are you aware of any bad odors or tastes from your mouth? YES NO
10. Is there anything you want us to know regarding your dental treatment? YES NO

If yes, _____

Some dental procedures take more time than others. If you are tired and want a break, or if your jaw gets tired from being open, please notify the dentist or hygienist so you can rest, making your dental visit a more pleasant experience.

DATE

X _____
PATIENT'S SIGNATURE (Parent or legal guardian if minor)

ACKNOWLEDGEMENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR EASTLAND DENTAL CENTER

Effective April 14, 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 your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for disclosures in connection with; a defense to a 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 make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures for your information in connection with providing or coordinating your treatment.

I understand that the practice routinely confirms appointments and reminders about premedication and may leave messages on an answering machine, voice mail, e-mail, postcards, or with another family member.

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our Notice of Privacy Practices

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

X _____
Patient, Authorized Representative or Legal Guardian Signature Patient Name (please print)
Relationship to Patient _____ Date: _____

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient name (Please print) Date

X _____
Patient, Authorized Representative or Legal Guardian Signature Relationship to Patient

Witness Signature Date

For Office Use Only

Patient refused to sign the; acknowledgement _____ consent _____

The following circumstances prohibited the patient, authorized representative, legal guardian from signing the acknowledgement _____ consent _____

____ An emergency situation existed preventing us from obtaining a signature ____ A communication barrier existed preventing us from obtaining signature ____ Other _____

Office Personnel Signature Office Personnel (print name)

Date: