Welcome

ABOUT YOU

Today's Date_____ Email Address_____

Name_____ I prefer to be called_____ Male __ Female__

Last First MI

Birthdate ___/___/___ Age _____ Social Security # _____ Single ___Married ___Divorced ___Widowed___

Home Address_____

Street City State Zip

Home Phone (____)_____ Mobile (____)_____ Work Phone (____)_____ Driver License_____

Where & when are best times to reach you? _____ Whom may we thank for referring you?_____

Employer _____ How long there?_____ Occupation_____

Employer's Address _____

Street City State Zip

Person Responsible for Account if other than yourself

Name_____ Relation_____ Home Phone (____)_____ Social Security # _____

Employer_____ Work Phone (____)_____ Drivers License _____

Billing Address _____

Primary Insurance Dental Coverage? Yes____ No____

Insurance Co Name _____ Phone (____)_____ Group # (plan or Policy) _____

Insurance Co Address _____

Street City State Zip

Insured's Name_____ Social Security #_____ Birthday ___/___/___ Relation_____

Insured's Employer_____ Employer's Address_____

Street City State Zip

Secondary Insurance Dental Coverage? Yes____ No____

Insurance Co Name _____ Phone (____)_____ Group # (plan or Policy) _____

Insurance Co Address _____

Street City State Zip

Insured's Name_____ Social Security #_____ Birthday ___/___/___ Relation_____

Insured's Employer_____ Employer's Address_____

Street City State Zip

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be_____

Signature _____Date_____

PAYMENT IS DUE AT TIME OF SERVICE

Our Office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____Insurance Co. and I assign directly to Dr. _____all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. Signature _____Date_____

Patient Acknowledgement and Consent Form

The federal law known as the Healthy Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that our office comply with certain rules regarding the maintenance of the privacy of our information that we have collected and will collect in the future.

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

Existing Michigan Law requires us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence, 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 license 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 or consult with another dentist or health care professional or otherwise make disclosures of your information in connection with providing or coordinating your treatment. Occasionally, this communication between dental offices regarding treatment or diagnosis may be in electronic form.

Patient Acknowledgement

Please sign below to acknowledge that you have received a copy of our Notice of Privacy Practices.

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

_____ _____

Patient Signature Patient Name (Please print)

Date: _____

Patient Consent

Please sign below 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 necessary in connection with my treatment. I consent that communication between myself and/or other health care professionals may be in electronic form and am aware that there is some level of risk of third parties being able to read unencrypted emails.

_____ _____

Patient Signature Patient Name (Please print)

Date: _____

For Office Use Only

The following circumstances prohibited the patient from signing the Acknowledgement:

___Individual refused to sign ___An emergency situation prevented us to obtain acknowledgement ___Other (Specify)

_____ _____ Date:_____

Office Personnel Signature Office Personnel (Print name)

Office Policy

Thank you for choosing White Lake Family Dentistry. Our primary mission is to deliver the best comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

White Lake Family Dentistry requires payment at time of service.

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- Convenient monthly payment options from CareCredit* credit card
    - Allows you to pay over time
    - No annual fees
- We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card when treatment is presented and scheduled.

Missed Appointments

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $55 per appointment. If your appointment is scheduled for longer than 90 minutes, our policy is to charge $100 per missed appointment. **
Our office reserves the right to dismiss a patient if there are three unexcused missed appointments. **

Consent for Treatment

I am aware that some changes in dental treatment may become necessary during the course of treatment, and that, if this be the case, these changes will be explained prior to the time they occur. It is my understanding that the fees quoted are estimates only and that some variations may occur. I have an obligation to pay for treatment provided at the completion of each appointment unless other arrangements have been made.

Please sign below stating you understand our policy regarding payments, missed appointments and that you consent to treatment.

_____ _____
Patient Signature Patient Name (Please print)

Date: _____

*Subject to credit approval
**Office policy is subject to change

Name: _____

Date: _____ Date of Birth: _____

White Lake Family Dentistry requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. Failure to provide the requested information will limit our ability to assess your needs and may result in our practice being unable to accept you as a patient. Thank you.

Medical History

*Do you (or have you ever had) any of the following? (Please check all that apply)*Red implies Antibiotic Pre-Med*

- ▫ Allergic Reaction to drugs or latex? (Circle all that apply)

  Latex Penicillin/Amoxicillin Sulfa Aspirin Codeine Local Anesthetics Metal Other

- ▫ Heart Attack or Heart Disease
- ▫ Stroke
- ▫ High Blood Pressure or Low Blood Pressure
- ▫ Congestive Heart Failure
- ▫ High Cholesterol
- ▫ Angina (intense chest pain)
- ▫ Irregular Heart Beat
- ▫ Artificial Heart Valve
- ▫ Heart Pacemaker
- ▫ Rheumatic Fever, Rheumatic Heart Disease
- ▫ Bacterial/Infective Endocarditis (SBE)
- ▫ Congenital Heart Disease
- ▫ Heart Murmur or Mitral Valve Prolapse
- ▫ Immunosuppressive Condition (Circle all that apply)

  Steroid Therapy (e.g. Prednisone)

  Radiation Therapy Chemotherapy

  SLE (Lupus) Rheumatoid Arthritis HIV/AIDS

  Organ Transplant Removed Spleen Other

- ▫ Inflammatory Disease – Specify: _____
- ▫ Bleeding or Clotting Disorders, Anemia, or Other Blood Disease
- ▫ Other Artificial Implants or Devices
- ▫ Artificial Joint(s) (Circle all that apply)

  Hip Knee Ankle Shoulder Other

  Date(s) Placed: _____

- ▫ Arthritis or Gout
- ▫ Osteoporosis – Please circle past Bisphosphonate therapy:

  Fosamax Actonel Boniva Aredia Zometa Reclast Other

- ▫ Diabetes (Type 1, Type 2, or Hypoglycemia) *Injection Oral*
- ▫ Glaucoma
- ▫ Thyroid Disease
- ▫ Parathyroid Disease
- ▫ Seizures or Nervous System Condition
- ▫ Stomach or Intestinal Disease
- ▫ Ulcers
- ▫ Acid Reflux
- ▫ Kidney Disease
- ▫ Hepatitis (A, B, C, D, or E)
- ▫ Leukemia

- ▫ Liver Disease
- ▫ Other Muscle or Joint Disease
- ▫ Sinus Trouble
- ▫ Asthma
- ▫ Tuberculosis
- ▫ COPD or Emphysema
- ▫ Sleep Apnea – Do you wear a C-pap? _____
- ▫ Other Lung Disea (Continue to Next Page) _____
- ▫ Mental Health Condition – Specify:_____
- ▫ Cognitive Impairment – Specify:_____
- ▫ Physical or Mental Disabilities that may require special care – Specify: _____
- ▫ Alzheimer's Disease or Dementia
- ▫ Back or Neck Issues
- ▫ Frequent Headaches
- ▫ Difficulty Hearing
- ▫ Do you or have you ever been treated for cancer?

  Specify: _____
- ▫ Are you or could you become pregnant?
- ▫ Are you or have you ever been addicted to a chemical substance or drug?

- ▫ Do you or have you had any other diseases or medical conditions NOT listed on this form? If so, please explain:

_____
_____
_____
_____

- ▫ None of the above medical conditions apply to me

Dental History

Do you (or have you ever had) any of the following?

- ▫ Chronic Bad Breath
- ▫ Blisters on Lips or Mouth
- ▫ Burning Sensation on Tongue
- ▫ Cigarette, Cigar, or Pipe Smoking
- ▫ Smokeless Tobacco
- ▫ Dry Mouth
- ▫ Clench or Grind Teeth
- ▫ Growths or Sore Spots in Mouth
- ▫ Swollen, Tender, or Bleeding Gums
- ▫ Head, Neck, or Jaw Pain
- ▫ Loose Teeth or Broken Fillings
- ▫ Mouth Breathing
- ▫ History of Periodontal Treatment
- ▫ Sensitivity to Sweets, Hot, Cold
- ▫ Have you ever had an allergic reaction to local or general anesthetics? – Specify: _____

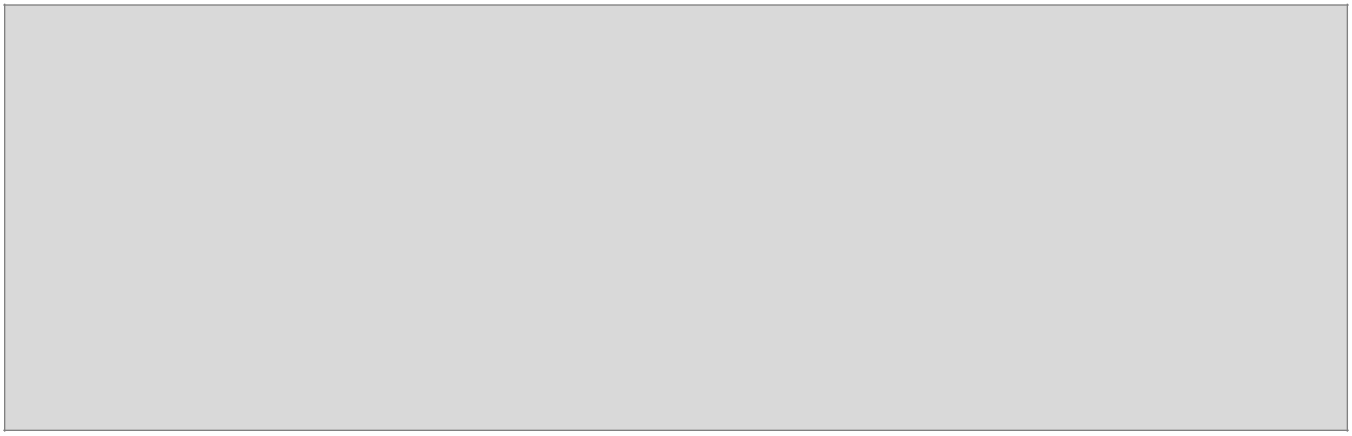
- ▫ Dental Anxiety or Fear of the Dentist? Please Explain:

  _____
  ___

  How often do you floss? _____ How often do you brush?
_____

Updates or Exceptions:
_____
_____
_____

For Clinician Use Only:



Name: _____

Date: _____ Date of Birth: _____

Medications

Please list all of the prescriptions and over-the-counter medication you are currently taking. Please leave the gray column blank.

Name of Medication	Dosage (if known)	Reason for medication?	Updates or Exceptions?	For Clinician Use Only

I hereby certify that I have read the above and have filled out the health questionnaire to the best of my knowledge. I have advised you of all of the medical conditions of which I am aware of. I further certify that I, the undersigned, consent to x-rays, examination, and treatment if deemed necessary.

Signature: _____ Date: _____