

**PATIENT REGISTRATION**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE **MI** ZIP \_\_\_\_\_

**RESPONSIBLE PARTY**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE **MI** ZIP \_\_\_\_\_

DRIVERS LICENSE # \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

HOME PH# ( \_\_\_\_ ) \_\_\_\_\_ BUSINESS PH# ( \_\_\_\_ ) \_\_\_\_\_ CELL PH# ( \_\_\_\_ ) \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE **MI** ZIP \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE# ( \_\_\_\_ ) \_\_\_\_\_

**DENTAL INSURANCE**

**Primary**

Subscriber (Employee) \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Employed by: \_\_\_\_\_

Dental Ins Co. \_\_\_\_\_

Phone: \_\_\_\_\_

Group/Policy# \_\_\_\_\_

**Secondary**

Subscriber (Employee) \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Employed by: \_\_\_\_\_

Dental Ins Co. \_\_\_\_\_

Phone: \_\_\_\_\_

Group/Policy# \_\_\_\_\_

**AUTHORIZATION, RELEASE, AND AGREEMENT**

I understand that I am responsible for payment of all services rendered on my behalf and on behalf of my dependent/s. I understand that payment is due at the time of service. I understand that I will be responsible for any fees charged to me for broken appointments or appointments canceled without 48 hours notice.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers/ and or other healthcare practitioners so that a claim for reimbursement can be filed on my behalf.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Dental History**

- Are you happy with the appearance of your teeth? (color, shape, size) Yes No
- Are your teeth temperature sensitive? (hot or cold) Yes No
- Are your teeth sensitive while biting or chewing? Yes No
- Do you frequently get cold sores, blisters, or other types of oral lesions? Yes No
- Have you ever had orthodontic treatment? (Braces) Yes No
- Do you brush and floss your teeth on a regular basis? Yes No
- Do your gums bleed? Yes No
- Do you have bad breath? Yes No
- Do you ever have clicking, popping, or discomfort in the jaw joint? Yes No
- Do you clench or grind your teeth? Yes No
- Do you use any form of tobacco? (Cigarettes, pipe, chewing tobacco) Yes No
- Do you have numbness or tingling in the fingertips? Yes No
- Do you snore excessively? Yes No
- Have you been diagnosed with sleep apnea? Yes No



**Tobacco Use**  
Tobacco use is the most significant risk factor for gum disease



**Women**  
Women with osteoporosis have a greater risk for periodontal bone loss



**Heart Attack/ Stroke**  
Untreated gum disease may increase your risk for heart attack or stroke



**Diabetes**  
Gum disease is a common complication of diabetes. Untreated gum disease makes it harder for patients with diabetes to control their blood sugar

**Medical History**

Are you allergic to any of the following?

Aspirin    Penicillin    Codeine    Acrylic    Metal    Latex

NSAIDS    Sulfa    Other (please list) \_\_\_\_\_

Do you have or have you had any of the following conditions?

<input type="checkbox"/> AIDS/ HIV positive	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Asthma/Emphysema	<input type="checkbox"/> Liver Disorder/ Jaundice
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Pacemaker/ Defibrillator
<input type="checkbox"/> Cancer	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Chemotherapy/ Radiation Therapy	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Congenital heart disease	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Swelling of Feet/Ankles
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Headaches	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Hepatitis A,B, or C (please circle)	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Xerostomia (Dry mouth)



**Medication**  
Side effects of some medications may cause changes in your gums

If you have any other serious illnesses/conditions not listed above please list and explain them here.

\_\_\_\_\_

Are you under a physician's care now?  Yes  No If yes please list Dr's name and # \_\_\_\_\_  
Please list any prescription drugs, herbal supplements, or over-the-counter products you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**stress**

High levels of stress can lower your body's immune defense

Signature \_\_\_\_\_ X

## 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.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment from your insurance company (if applicable) for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. Unless you request otherwise, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Patients 18 years and over will be considered as an adult and will be responsible for making their own decisions in regards to their dental care.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your

health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies of recent radiographs, we will fulfill your request free of charge. However, if you require any further chart history or a summary of your dental information, we will charge you \$25.00 for staff time to process this request. Contact us using the information listed at the end of this Notice for a full explanation of this policy.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Susan Hedlund \_\_\_\_\_

Telephone: (248) 656-2020 \_\_\_\_\_ Fax: (248) 656-2559 \_\_\_\_\_

E-mail: \_\_\_\_\_

Address: 433 W. University Rochester, Mi, 48307 \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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