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 .

☐ Male ☐ 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: ☐ Patient ☐ Parent ☐ Legal Guardian ☐ 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 Name: _____ Phone. _____	Employee Address: Employee Social Security No . Group No. Union/Local No

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

[redacted] _____ [redacted] _____

*** 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 eligiblity. 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.

[redacted] _____ [redacted] _____

(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.

[redacted] X _____ [redacted] _____

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

(antibotics may decrease effectiveness or 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.

_____ X _____

[redacted] (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.

_____ X _____

[redacted] [redacted]t or legal guardian if minor)

ACKNOWLEDGEMENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR UNIVERSAL 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 _____ _____

[redacted]**esentative or Legal Guardian Signature** Patient Nam[redacted]

Relationship to Patient _____ [redacted]

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[redacted]

X _____ _____

[redacted]**l 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: _____