Patient Registration

Welcome to our practice. The benefits of a happy healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for your dental needs.

ABOUT YOU

TODAY'S DATE : ________________

NAME: ____ Preferred Name: ____________________

First MI Last

Address: ________________________________ City, State, Zip: ______________________________

Home Phone: _______________ Cell Phone: _______________ Work Phone: _______________ Ext# _________

E-Mail Address: ____________________________ Would you like e-mails on office updates? ☐ Yes ☐ No

Birth Date: _____/_____/_______ Social Security # __________________ Drivers License ____________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Separated

What is the reason for your visit to our office today ______________________________

Referral: Whom may we thank for referring you? _________________ Other Family Members seen by us: _______________

Previous / Present Dentist: __________________________ Last Visit Date: _________________________

Spouse / Guardian Information:

His / Her Name: ______________________ Employer: __________________ Work Phone: __________ Ext# _____

Social Security # _______________ Birth Date: _____/_____/_______ Drivers License: ____________________

Employment:

Employer: ________________ Occupation: _____________ How long there? _____ ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time School Name: ____________________ City, State: ___________________

DENTAL INSURANCE INFORMATION

Primary:

Name of Insured: ___________________________ Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's SSN or ID ____________________ DOB _____/_____/_____ Relation ______________________

Insured's Employer: __________________________ Insurance Company Name: _________________________

Phone # _______________ Group # ____________

Secondary:

Name of Insured: ___________________________ Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's SSN or ID ____________________ DOB _____/_____/______ Relation ______________________

Insured's Employer: __________________________ Insurance Company Name: _________________________

Phone # _______________ Group # ____________

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________________________

Phone: ____________ Date of last visit _____________

Please explain why under care of physician ______________

____

EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: ___________________________

Relation: ________________________________

Wk# _______________ Hm # _______________

HEALTH HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, ____________________

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, ____________________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, ____________________

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, ____________________

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, ____________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes, ____________________

Are you on a special diet? ☐ Yes ☐ No If yes, ____________________

Do you use tobacco? ☐ Yes ☐ No If yes, ____________________

Do you use controlled substances? ☐ Yes ☐ No If yes, ____________________

Do you experience dry mouth or bad breath? ☐ Yes ☐ No If yes, ____________________

Do your gums ever bleed? ☐ Yes ☐ No If yes, ____________________

Women: Are you Pregnant ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

ALLERGIES

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa ☐ Clindamycin ☐ Dental Anesthetics ☐ Tetracycline ☐ Erythromycin ☐ Jewelry ☐ Ibuprofen ☐ Keflex ☐ Other ____________________

HEALTH HISTORY

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

Condition	Yes	No
AIDS / HIV Positive	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Arthritis / Gout	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No
Cold Sores / Fever Blister	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No
Excessive Thirst	☐ Yes	☐ No
Fainting/Dizziness	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No
Frequent Diarrhea	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No
Genital Herpes	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Heart Attack / Failure	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No
Heart Trouble / Disease	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis A /B/ C	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Hives or Rash	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Pain in Jaw Joints	☐ Yes	☐ No
Parathyroid Disease	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatments	☐ Yes	☐ No
Recent Weight Loss	☐ Yes	☐ No
Renal Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Rheumatism	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shingles	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Spina Bifida	☐ Yes	☐ No
Stomach / Intestinal	☐ Yes	☐ No
Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swelling of Limbs	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumors or Growths	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Yellow Jaundice	☐ Yes	☐ No

Sleep Apena Screening:

Do you snore? ____________

Are you tired, fatigued or sleepy during the day? ____________

Do you have high blood pressure? ________

Do you gasp while sleeping? ________

Have you had a home sleep study? ________

How long ago? ________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical condition. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that I am responsible for payment of services rendered and also responsible for paying and co-payment and deductibles that my insurance does not cover. Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Signature of Patient, Parent or Guardian ____________________ Date ____________________

HIPPA Notice of Privacy Practices

Lapeer City Dental

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you including demographic information, which may identify you and that, relates to your past, present, or future physical or mental health or condition related to health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.

Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, licensing, market and fundraising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when your dentist or hygienist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceeding: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker’s Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other Permitted and Required Disclosures:

Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.

Under Federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.

This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that ant part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If a dentist believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to the Secretary of health and Human Services if you believe that we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact of your complaint; **we will not retaliate against you for filling a complaint.**

This was published and becomes effective on/or before **April 14, 2003**

Print Name Signature Date

Lapeer City Dental

TREATMENT CONSENT FORM

What you are being asked to sign is a confirmation that we have/will discuss the nature and the purpose of dental treatment, the known risks associated with dental treatment, and the feasible treatment alternatives, and that you have been (will be given) an opportunity to ask questions, and that all of your questions have been answered in a satisfactory manner to your understanding. Please read this form carefully before signing it and ask about anything that you do not understand.

My signature on the bottom of this form certifies that:

1.) I will be/have been informed and understand that the practice of dentistry is not and exact science; no guarantees or assurance as to the outcome of prosthetic treatment or surgery can be made due to the uniqueness of every clinical situation. In most instances, the outcome of treatment is most satisfactory.
2.) I understand that unforeseen conditions or circumstances may arise during the course of treatment and that additional treatment not specified in my treatment plan may be necessary. I will be advised of any additional treatment and estimated costs should the need arise.
3.) I understand that the estimate given to me is for normal and usual treatment. I understand that if my treatment requires extra time, additional procedures or additional laboratory work, there will be additional fees related to the additional time and treatment. Normal and usual treatment consists of 1 or 2 try ins of the restoration and up to 5 post-insertion adjustments.
4.) I understand that Dr. Brower / Dr. Solt will (have) carefully examined my mouth. Alternatives to the chosen treatment have been explained. I have been informed and I understand the purpose and the nature of the dental procedure. I understand the procedures that are necessary to accomplish completion of the dental treatment and fabrication of the prosthesis.
5.) I will be/have been informed of the possible risks and complications involved with surgery, drugs and anesthesia that include but are not limited to the following: pain, swelling, infection, discoloration, inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing and allergic reactions to drugs or medications prescribed. Numbness of the lip, tongue, chin, cheek, or teeth may also occur, for which the exact duration may not be determinable and may be irreversible.
6.) I will be/have been informed of the possible risks and complications involved with dental treatment that include but are not limited to; root canal therapy, fracture of teeth or roots, fracture of porcelain or acrylic, loss of cementation, decay around restorations and possible loss of teeth. I understand that these complications may necessitate further treatment.
7.) I understand that if nothing is done, any of the following may occur; loss of teeth, loss of bone, gum tissue inflammation, infection, decay, sensitivity, looseness of teeth followed by the need for extraction, fracture of teeth/ and or roots, difficulties in chewing and/ or speech. Also possible are temporomandibular (TMJ) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.

(Over)

8.) Lapeer City Dental will/has explained that there is no method to accurately predict the outcome of dental treatment due to large variations in teeth, gums, bone, chewing forces, and oral hygiene. It has been explained to me that in some instances dental treatment may not be successful.

9.) I agree to follow the home care instructions provided to me. I agree to report to Dr. Brower and or / Dr. Solt for regular examinations as indicated and I understand that this office will monitor my progress unless I have been advised to return to my general dentist for dental care.

10.) To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic reactions to drugs, food, insect bites, anesthetics, pollens, dust, any blood diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

11.) I consent to photography, study models and x-rays of the procedure to be performed for use in teaching dentistry and other graphic purposes.

12.) I understand that with any dental treatment, my teeth, gums or bone can be damaged by bacteria and I must do my utmost to remove that bacterial plaque off all the surfaces of all my teeth and/or implants every day. If I do not clean my teeth and/ or implants properly, I may get decay and/ or gum disease and my treatment may fail.

I have been fully informed of the nature of dental treatment along with possible risks and complications and hereby consent to treatment.

____

Date Print Name Signature of Patient/ Guardian

____

Date Print Name Signature of Doctor

____

Date Print Name Signature of Witness