MI Beautiful Smile

PATIENT HEALTH AND HISTORY PAGE 1 of 2

PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ Gender: _____

Employer: _____

Employer's Address: _____
Street

_____
City State Zip

Home Phone : _____

Cell Phone: _____

Social Security #: _____

Marital Status: _____

Work Phone: _____

Email: _____

Who may we thank for referring you:
_____

SPOUSE INFORMATION

Spouse's Name:_____

Spouse's Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____

Phone: _____ Work Phone: _____ Email: _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Co. Name:_____ Insurance Co. Phone: _____

Insured's Name: _____ Relationship: _____

Insured's SS#: _____ Group/ID #: _____

Insured's Birthdate: _____ Insured's Employer: _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Co. Name:_____ Insurance Co. Phone: _____

Insured's Name: _____ Relationship: _____

Insured's SS#: _____ Group/ID #: _____

Insured's Birthdate: _____ Insured's Employer: _____

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PATIENT HEALTH AND HISTORY PAGE 2 OF 2

DENTAL HISTORY

Do you require antibiotics (PRE-MED) before dental treatment? _____
If Yes, Which antibiotic and dosage? _____
Have you ever had gum disease? _____ Do your gums ever bleed? _____
Do you now (or have you ever) experienced pain/discomfort in your jaw TMJ/TMD? _____
Previous dentist: _____ Last dental visit date: _____

MEDICAL HISTORY

Your physician's name: _____ Physician's phone: _____
Do you take blood thinner or blood pressure medications? _____
Your current medications: _____
_____
Are you taking them as directed? _____ If No, please explain: _____
Are you taking any non-prescription or herbal medications or supplements? _____
_____

Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Aspirin	___	___	Dental Anesthetics	___	___	Latex	___	___	Sulfa Drugs
___	___	Barbiturates	___	___	Erythromycin	___	___	Penicillin	___	___	Tetracycline
___	___	Codeine	___	___	Jewelry/Metals	___	___	Sedatives	___	___	Iodine

List any additional drugs/materials that cause allergic reactions: _____
_____

Yes	No		Yes	No		Yes	No	
___	___	Abnormal Bleeding	___	___	Eating Disorders	___	___	Nervous Problems
___	___	Acid Reflux	___	___	Epilepsy	___	___	Oral Surgery
___	___	AIDS/HIV	___	___	Fainting Spells	___	___	Pacemaker
___	___	Alcohol Addiction	___	___	Frequent Headaches/Migraines	___	___	Periodontal Surgery
___	___	Arthritis	___	___	Heart Attack	___	___	Prosthetic Joints
___	___	Artificial Heart Valves	___	___	Heart Murmur	___	___	Radiation/Chemo Treatments
___	___	Asthma	___	___	Heart Surgery	___	___	Rheumatic Fever
___	___	Blood Disease	___	___	Hemophilia	___	___	Scarlet Fever
___	___	Blood Transfusions	___	___	Hepatitis (type and date_____)	___	___	Sinus Problems
___	___	Cancer	___	___	High Blood Pressure	___	___	Smoke or Use Tobacco
___	___	Chest Pains	___	___	Implants (any type)	___	___	Stroke
___	___	Circulatory Problems	___	___	Kidney Disorders	___	___	Thyroid Problems
___	___	Complication from Dental Surgery	___	___	Liver Disease	___	___	Tuberculosis
___	___	Convulsions or Seizures	___	___	Low Blood Pressure	___	___	Ulcers
___	___	Diabetes Type I or Type II	___	___	Mitral Valve Prolapse	___	___	Venereal Disease
___	___	Drug Abuse						

Please explain any hospitalizations, surgeries, or serious medical conditions: _____
_____
For women: Are you taking birth control pills? _____ Are you pregnant? _____ Week #: _____ Are your nursing? _____

I affirm that the information I have given is correct to the best of my knowledge. 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 service I may need. I understand that I am responsible for payment of all dental services rendered, but as a service to me, this office will submit dental claims. I assign to MI Beautiful Smile, all insurance benefits, otherwise payable to me. I authorize them 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. Payment is due at the 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 ADA.

Signature: (Patient / Legal Guardian): _____ **Date**: _____

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require 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 the HIPAA's requirements, we are giving you a copy of Notice of Privacy Practices. This Notice of Privacy Practices contains the information that 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 our disclosures in connection with: a defense to 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 may make a referral to of consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have received a copy of our notice of privacy practices.

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

Patient/Parent/Guardian Signature: _____ Date: _____

Patient/Parent/Guardian Name (Please print): _____

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/Parent/Guardian Signature: _____ Date: _____

Patient/Parent/Guardian Name (Please print): _____

For office use only

Patient Refused to sign

The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient from signing the Acknowledgement.

Office Personnel Signature: _____ Date: _____

Office Personnel Printed Name: _____

MI Beautiful Smile

FINANCIAL POLICY

Our office has always been happy to work with patients regardless of dental coverages. We think insurance is a great incentive to maintain a vital level of dental health. But it is a rare, very rare dental plan that covers 100% of our fees.

Here is why:
The fees we charge for dental services are the same for every patient, insured or not. A given insurance policy, however, is based on a fixed fee schedule, "what your insurance company or employer will pay based on your individual employer will pay based on your individual policy. "

MI Beautiful Smile is not a provider for every insurance company. Your dental insurance is your financial responsibility. Please realize that it is a courtesy to you that we verify dental benefits and bill your insurance. We also as a courtesy provide an estimate of co-pay however, regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you the patient, parent, or guardian, are responsible for the total cost of your dental treatment. You are responsible at the time of your appointment, for any deductible and co-payment not covered by your insurance carrier. Once our office has received payment from the insurance company, if any balance is remaining, you will be billed within 30 days.

You may make any payment using cash, check, credit card or Care Credit. Care Credit is an outside finance company we offer that will allow you to take advantage of the interest free financing.

I understand and acknowledge that I am financially responsible for the services provided to myself, another family member, regardless of insurance coverage.1

Signature of Responsible Party: _____

Date: _____

7550 Village Court, Davisburg, MI 48350
Phone 248.634.7002 Fax 248.634.9973 MIBeautifulSmile.com

MI Beautiful Smile

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (patient), authorize MI Beautiful Smile, to take photographs, and/or videos of my face, jaws, and teeth before, during and after treatment.

I consent to allow the photographs to be used for the following purposes:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations and professional publications such as journals or books.
- Marketing materials, including websites, printed materials, and patient education.
- I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.
- I do not expect compensation, financial or otherwise, for the use of these photographs.

____ Check here if you ***do not*** want your full face shot used for any of the above purposes.

Signature (Patient/Legal Guardian): _____

Date: _____

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