Blue Water Dentistry

www.bluewaterdentistry.com
3185 Corporate Grove Dr. | Suite A • Hudsonville, MI 49426-8021
smile@bluewaterdentistry.com
(616)896-7600

Welcome to our Practice

Patient Name: ______________________ * ______________________ * ____ ______________
Last / First / M / Preferred Name

Parent/Guardian

____

____

Address: ______________________ * ______________________
Address 1 / Address 2

______________________________ * ________ * ____-____ *
City / State / Zip Code

Home Telephone: ______________

Mobile Telephone ______________

How did you hear about our practice?

____

In an emergency who should be notified? Please enter Name and Phone number below:

____

____

HIPAA Acknowledgement/Notice of Privacy Practices

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process you insurance claims.

☐ **By checking this box, I acknowledge that I have been offered/received a copy of this office's Notice of Privacy Practices.**

I understand that I may inspect or copy the protected health information described by this authorization. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care will not be affected if I refuse to sign this form.

____
Please PRINT name of Patient

____
Please PRINT Guardian/Legal Representative

____
Relationship of Guardian/Legal Representative

Signature ______________________________________ **Date** __________

Please list any other parties who can have access to your health information (This includes step parents, grandparents, and any care givers who can have access to this patient's health information). I authorize Blue Water Dentistry to contact the individual(s) listed below to convey any pertinent information to me, in the event that I am unable to be reached by the dental office (including, but not limited to any and all dental information and lab/scan results):

Name:________________________ Phone# (_____)____________ Relationship to patient______________________
Name:________________________ Phone# (_____)____________ Relationship to patient______________________
Name:________________________ Phone# (_____)____________ Relationship to patient______________________

I authorize contact from this office with specific information regarding my appointments, treatment, and billing via:

☐ Cell Phone including voicemail ☐ Home Phone including voice message ☐ Work Phone including voice message
☐ Text Message to my Cell Phone ☐ Email Confirmation ☐ ANY OF THE ABOVE

I authorize INFORMATION ABOUT MY HEALTH be conveyed via:

☐ Cell Phone including voicemail ☐ Home Phone including voice message ☐ Work Phone including voice message
☐ Text Message to my Cell Phone ☐ Email Confirmation ☐ ANY OF THE ABOVE

No Show/Cancellation Policy

We kindly ask that you provide 24 hours notice if you are unable to keep a scheduled appointment. Failure to do so may result in a "Broken Appointment" fee charged to your account. Payment of this fee will be required prior to rescheduling of a new appointment. Multiple missed appointments may result in discharge from our practice. Exceptions will be made on a case by case basis. This policy is for new and existing patients in our practice. Thank you in advance for your cooperation.

Consent for Services and Financial Policy

We require that you pay your estimated patient portion on the day the dental service is provided.
We will bill your insurance carrier(s) as a courtesy to you, although you are responsible for the entire balance. We will set aside for 30 days that portion of the balance which we estimate your insurance carrier will pay. If your insurance carrier does not send payment within 30 days, the remaining balance will be due in full from you. We are not a party to the agreement with your insurance carrier. It is therefore your responsibility to contact your carrier and establish why they haven't paid or paid less than originally stated. If your carrier later pays us more than the estimated balance, we will promptly refund the difference to you.
We currently only participate with Delta Dental as a Premier provider. We do work with all dental insurance companies.
If you do not have dental insurance, we require payment in full on the day the dental service is provided, unless financial arrangements have been made with Care Credit.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature.**

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

For Office Use Only

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
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (please specify)

Response Date: __________

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Patient Name: ____________ * ____________ * ____ ____________
Last First MI Preferred Name

Please indicate if you have or have not had any of the following diseases or problems.

AIDS/HIV Infection *	○ Yes ○ No	Abnormal bleeding *	○ Yes ○ No
Acid Reflux *	○ Yes ○ No	Anemia *	○ Yes ○ No
Angina/Chest Pain *	○ Yes ○ No	Artificial Joints *	○ Yes ○ No
Asthma *	○ Yes ○ No	B-12 Deficiency *	○ Yes ○ No
Blood Thinners *	○ Yes ○ No	Cancer/Chemo/Radiati *	○ Yes ○ No
Cold Sores/Herpes *	○ Yes ○ No	Contact Lenses *	○ Yes ○ No
Diabetes *	○ Yes ○ No	Eating disorder *	○ Yes ○ No
Emphysema *	○ Yes ○ No	Epilepsy/Seizures *	○ Yes ○ No
Fainting/Dizziness *	○ Yes ○ No	Glaucoma *	○ Yes ○ No
HPV *	○ Yes ○ No	Head Injuries *	○ Yes ○ No
Heart Attack *	○ Yes ○ No	Heart Disease *	○ Yes ○ No
Hepatitis-what type? *	○ Yes ○ No	High Blood Pressure *	○ Yes ○ No
Kidney Disease *	○ Yes ○ No	Liver Disease *	○ Yes ○ No
MRSA *	○ Yes ○ No	Mental Disorders *	○ Yes ○ No
Neurologic Disorders *	○ Yes ○ No	Other infection *	○ Yes ○ No
Pacemaker *	○ Yes ○ No	Persistent cough *	○ Yes ○ No
Previous Biopsies *	○ Yes ○ No	Rapid weight changes *	○ Yes ○ No
RespiratoryCondition *	○ Yes ○ No	Sleep Apnea *	○ Yes ○ No
Stomach Condition *	○ Yes ○ No	Stroke *	○ Yes ○ No
Swollen lymph nodes *	○ Yes ○ No	Thyroid Disease *	○ Yes ○ No
Tuberculosis *	○ Yes ○ No	Ulcers *	○ Yes ○ No

Please explain any "yes" answer below.

____

____

Have you been hospitalized in the last 5 years? If so, please explain. ○ Yes ○ No

____

Are you currently receiving medical care? If so, please explain. Please list all the names and specialties of the physicians who are currently providing you care:

____

____

Do you have any of the following?

☐ Artificial (prosthetic) heart valve

☐ History of previous infective endocarditis

☐ Damaged valves in transplanted heart

☐ Congenital heart disease (CHD) that is unrepaired, repaired in the last 6 months, or repaired with residual defects

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ○ Yes ○ No

Are you required to PRE-MEDICATE before dental treatment? If so, please explain: ○ Yes ○ No

Do you have a history of abnormal blood pressure? If yes, what is it usually? ○ Yes ○ No

Since 2001, have you had or are you scheduled to begin treatment with an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia, Paget's disease, multiple myeloma, or metastatic cancer?
If so, please list the date that treatment began and the date of last treatment.

___

___

Women:

Are you pregnant? ○ Yes ○ No

If no, area you planning a pregnancy in the near future? ○ Yes ○ No

Are you a nursing mother? ○ Yes ○ No

Are you allergic or have you had a reaction to?

Local anesthetics ○ Yes ○ No

Penicillin or other antibiotics ○ Yes ○ No

Aspirin or other NSAIDS ○ Yes ○ No

Codeine, Valium, or other sedatives? ○ Yes ○ No

Latex ○ Yes ○ No

Foods, gluten, or dyes ○ Yes ○ No

Please list additional allergies ___

Are you a tobacco user? If yes, in what form and how much per day? ○ Yes ○ No

Please list any medications and/or supplements that you are currently taking:

___

___

___

___

___

Preferred Pharmacy:

____

____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature ____ **Date** ________

Dental Status

What is the reason for today's visit?

____

____

Are you happy with the appearance and function of your teeth and smile? If not, what would you like to change?

○ Yes ○ No

____

What is the date of your last dental exam? __________

Previous dentist's name and phone number or city where they are located?

____

____

Have you been diagnosed with or had any treatment for periodontal (gum) disease? ○ Yes ○ No

Have you had previous orthodontic treatment? (i.e. braces, retainers, etc.) ○ Yes ○ No

Do you wear a removable dental appliance? (i.e. retainer, bite splint, etc.) ○ Yes ○ No

Is your home water fluoridated? ○ Yes ○ No

How often do you brush your teeth?

○ 2+ times per day ○ 1 time per day ○ A few times per week ○ Rarely or never

How often do you floss? __________________

Do you consume sugary beverages (i.e. pop, tea, coffee, juice, energy drinks)

○ Never/Rarely ○ Moderately (a few times per week) ○ Once Daily

○ Frequently (many times per day)

Do you or have you experienced any of the following? If so, please indicate those which you would like addressed.

☐ Tooth sensitivity
☐ Dry Mouth
☐ Snoring or sleep apnea
☐ Clenching and grinding
☐ Food catching in teeth
☐ Other - please explain
☐ Bleeding gums
☐ Jaw pain, earaches, face pain, neck pain
☐ Sores in your mouth
☐ Trouble getting numb
☐ Burning Sensation in Mouth

____

Response Date: ____________