Updated _____
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# PATRICIA A. BURNESS DDS, PC
# 1448 SOUTH GRATIOT
# MT. CLEMENS, MICHIGAN 48043
# (586) 954-3840

Today's Date_____

Patient Name_____ Date Of Birth_____

Address_____ City_____ Zip_____

Home Phone (  ) _____Business Phone (  ) _____

Name of Spouse/Parent (circle)_____ Referred By_____

Family Physician_____ Physician's Number (  ) _____

In Case of an Emergency, contact (name and number)_____

| **MEDICAL HISTORY** | **YES** | **NO** |
|---|---|---|
| 1. Do you consider yourself to be in good health?…….. | ☐ | ☐ |
| 2. Are you being treated for any condition by a physician now?…… | ☐ | ☐ |
| 3. Are you taking any medication at this time?…….. If yes, what kind_____ _____ | ☐ | ☐ |
| 4. Have you ever had an operation or serious illness?……. If yes, what and when_____ _____ | ☐ | ☐ |
| 5. Have you ever been told to premedicate?…… | ☐ | ☐ |
| 6. Women: Are you pregnant at the present time?…… | ☐ | ☐ |

7. As far as you know, are you allergic to any of the following? Please Check if Yes:

| | | |
|---|---|---|
| ☐ Local anesthetic (novacaine) | ☐ Codeine | ☐ Sulfa |
| ☐ Penicillin | ☐ Iodine | ☐ Latex |
| ☐ Other antibiotics | ☐ Aspirin | ☐ Other_____ |

8. Have you ever had any of the following? Please Check if Yes:

| | | |
|---|---|---|
| ☐ Rheumatic Fever | ☐ Ulcers | ☐ Venereal Disease |
| ☐ Heart Murmur | ☐ Asthma, Hay Fever | ☐ HIV/AIDS |
| ☐ Heart Disease | ☐ Tuberculosis | ☐ Eye Disorders |
| ☐ Stroke | ☐ Persistent Cough | ☐ Fainting Spells |
| ☐ High/Low Blood Pressure | ☐ Blood Disorder/Anemia | ☐ Epilepsy |
| ☐ Mitral Valve Prolapse | ☐ Thyroid Disease | ☐ Psychiatric Treatment |
| ☐ Chest Pain Upon Exertion | ☐ Hypoglycemia | ☐ Injury To Face/Jaws |
| ☐ Shortness Of Breath | ☐ Diabetes | ☐ Jaundice/Hepatitis |
| ☐ Congenital Heart Lesions | ☐ Frequent/Severe Headaches | ☐ Arthritis/Rheumatism |
| ☐ Kidney/Bladder Disorder | ☐ Cancer/Tumor | ☐ Cortisone Treatment |
| ☐ Bacterial Endocarditis | ☐ Prosthetics/Knee Or Hip Replacement | ☐ Chemo/Radiation Treatment |

9. When was your last dental check-up visit? _____

10. Is there any other health information that was not asked, which you feel may influence your dental treatment?

_____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any changes in my health, or if any of the medications change, I will inform the dentist or staff at next appointment without fail.

Signature of Patient (or parent if minor)_____

**PATRICIA A. BURNESS DDS, PC**
**1448 SOUTH GRATIOT**
**MT. CLEMENS, MICHIGAN 48043**
**(586) 954-3840**

## PATIENT INFORMATION

Patient's Full name_____ Sex_____

Street Address_____

City, State & Zip_____

Home Phone_____ Work Phone_____

Date Of Birth_____ Social Sec. #_____

Responsible Party_____ Marital Status (circle) Single Married Other

Employer's Name, Address and Number_____

_____

Driver License #_____

## INSURANCE INFORMATION

Name Of **First** Dental Insurance_____ Group #_____

Name Of Insured (employee)_____ Birthdate Of Insured_____

Insured's Social Security # _____

Patients Relationship To Insured ☐ Self ☐ Spouse ☐ Child

Employer of Insured_____ Employer's Phone_____

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Name Of **Second** Dental Insurance_____ Group #_____

Name Of Insured (employee)_____ Birthdate Of Insured_____

Insured's Social Security # _____

Patients Relationship To Insured ☐ Self ☐ Spouse ☐ Child

Employer of Insured_____ Employer's Phone _____

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I understand that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I also understand that payment is due at time of service, unless special prior arrangements have been made with Dr. Burness' financial manager. I also understand I may incur interest on any unpaid balances. I certify this information is true and correct to the best of my knowledge.

SIGNATURE_____ DATE_____

I hereby authorize the release of any medical information necessary to process claims for dental services performed on me. I also request payment be sent to the provider of these services; Patricia A. Burness, DDS, PC

SIGNATURE_____ DATE_____

# Patricia A. Burness, DDS, PC

1448 South Gratiot
Mt. Clemens, MI 48043
Office: (586) 954-3840
Fax: (586) 954-3843

*Patient Acknowledgement and Consent Form*

As of April 14, 2003, a new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") now 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.

One requirement of HIPAA is we are giving you a copy of our 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 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 may make referral to or consult with another dentist or 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 section of the form below the heading "Patient 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.

Please Print Name _____ Date _____

Relationship to Patient _____ Signature _____

*Patient Consent*
Please sign this section of the form below the heading "Patient 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, that you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above. I further understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature _____ Relationship to Patient _____

**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 _____ Office Personnel (please print) _____ Date _____

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## PATIENT PHI RELEASE FORM

In accordance with the HIPAA Regulation Privacy Act, I am giving authorization to the office of Patricia A. Burness to release any protected health information to those persons listed below. I understand that the person(s) below will be required to give an identifier number with any release of information, which is the last four digits of my Social Security number.

I, _____ , under any circumstance hereby authorize the release of my protected health information, which may include medical information, such as reports or films and insurance information to those person(s) indicated below:

Information may be released to the following:

| | | |
|---|---|---|
| Spouse _____ | ☐ Yes | ☐ No |
| Child _____ | ☐ Yes | ☐ No |
| Child _____ | ☐ Yes | ☐ No |
| Child _____ | ☐ Yes | ☐ No |
| Parent(s)_____ | ☐ Yes | ☐ No |

Other Family Members: *(please list)*

_____

_____

_____

Caregivers: *(please list*)

_____

_____

_____

_____ _____

Patient signature Date

The information on this form will be in effect from the date of signature. If you wish to amend or revoke this information, please contact us in writing at the address above.