PATIENT REGISTRATION

Name_____ Date of Birth_____

Address_____City_____ State_____ Zip_____

Cell Phone_____ Work Phone_____Home Phone_____

Would you like a Text Appointment Confirmation (when available)? ___YES ___NO

__Male __Female __Single __Married __Separated __Divorced __Widowed

Social Security Number(for insurance)_____ Driver's License and State _____

Employer_____ Location_____ Position_____

Primary Dental Insurance Co. _____Group # _____ Subscriber ID_____

Secondary Dental Insurance Co. _____Group # _____ Subscriber ID _____

RESPONSIBLE PARTY (for children thru 17 or patients with guardians) Otherwise just write self.

Name _____ Birthdate_____ Cell/Home Phone _____

Relationship to Patient _____

Social Security Number_____ Driver's License and State _____

Address_____ City_____State_____ Zip_____

Responsible Person's Employer _____

Business Address _____City _____ State _____ Zip_____

Spouse's Name(If applicable) _____Social Security #_____ Birthdate _____

Spouse's Employer _____ Spouse's Cell Phone_____

Spouse's Work Address _____ City _____State _____ Zip _____

How did you hear about our office?

___Referred by a friend ___Digital Advertising ___On-line (directory or advertisement) ___Insurance Plan

___Discount Mailer (i.e. Valpak) ___Drive-by/Signage ___Postcard or Letter ___I am a current Patient

If you were referred, who may we thank you for referring you? _____

CONSENT

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor. I understand that if my insurance does not pay as expected, then I am responsible for balance,

_____ _____ _____

Signature Date Relationship to Patient

PATIENTS DENTAL HEALTH

Why have you come to see us today? (pain, checkup, etc)_____

Previous Dentist_____ Last Visit_____ Date of last cleaning_____

Reason for Changing Dentist_____

What problems have you had with [past dental treatment? _____

Are you nervous about seeing a dentist? _____Yes _____No If yes, please tell us why_____

How often do you brush? _____ Do you floss? _____Yes _____No How often? _____

(Please Circle Each)

Y N I clench or grind my teeth during the day or while sleeping
Y N My gums bleed while brushing or flossing
Y N I like my smile
Y N I prefer tooth colored fillings
Y N I avoid brushing part of my mouth due to pain
Y N My gums feel tender or swollel
Y N I have problems eating
Y N I have had orthodontics
Y N I have had a facial or jaw injury
Y N I want my teeth straight
Y N I want my teeth whiter

What are your dental priorities? _____
(e.g. dental health, financial considerations, etc.)

PATIENT'S MEDICAL HISTORY

I consider my health to be (please circle one) Excellent Good Fair Poor

Do you or have you had any of the following? Please circle Y for Yes or N for No

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure High or Low
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints:_____ Hip_____ Knee_____ Other
16. Y N I smoke or use tobacco If Yes, how much per day? _____ How many years? _____
17. Y N I have consumed alcohol in the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment
19. Y N I have had a major surgery: Year _____ Type of Operation _____ Year _____ Type of Operation_____
20. Y N Liver Disease
21. Y N Jaundice
22. Y N Hepatitis Type_____
23. Y N Diabetes
24. Y N Excessive Urination/Thirst
25. Y N Infectious Mononucleosis (Mono)
26. Y N Herpes
27. Y N Arthritis
28. Y N Sexually Transmitted/Venereal Disease
29. Y N Kidney Disease
30. Y N Tumor or Malignancy
31. Y N Cancer/Chemotherapy_____
32. Y N Radiation Treatment
33. Y N History of Drug Addiction
34. Y N AIDS
35. Y N Immune Suppresses Disorder
36. Y N Hearing Loss
37. Y N Fainting Spells
38. Y N Glaucoma
39. Y N History of Emotional or Nervous Disorder

WOMEN

40. Y N Are you taking birth control medication
41. Y N Are you or could you be pregnant or nursing
42. Y N Have you taken Fosamax for Osteoporosis?

Do you have any other medical problem or medical history NOT listed on this form? _____

Are you allergic to ANY of the following?
Please circle Y for yes N for No

Y N Aspirin
Y N Ibuprofen
Y N Sulfa Drugs/Sulfites/Sulfides
Y N Penicillin
Y N Codeine
Y N Latex, Metals, Plastic
Y N Local Anesthetics (Novocaine)
Y N Other Medications-which ones? _____

Please list ALL medications you are currently taking

Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Physician's Name_____ Phone Number_____
Fax Number_____

I have answered all health questions to the best of my knowledge

Sinature_____Date_____Reviewed By_____Date_____

Mark J Halboth DDS PC
Awesome Dental
36000 5 Mile Rd
Livonia MI 48154
734-464-3430

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information that we created or received before we make the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information provided at the top of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician, pharmacist, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you, including your insurance company.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Michigan Dental Patient Consent Law (MCLA 333.16648): We are required by Michigan law to obtain your written consent prior to making certain disclosures of your health information.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement, disclosing only health information that is directly relevant to the persons involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or other possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Signature of Patient or Parent if minor **Date**

Mark J Halboth DDS PC

Awesome Dental

Over 18 HIPAA Release and Consent

I understand and acknowledge that as of my 18th birthday, I must grant permission for my parents and/or guardians to speak to, see my records, or handle my account or insurance information at your office. I also give them permission to schedule any appointments I may need for my dental care. I also acknowledge that if my account is not paid by my parents, that I am responsible for my account balance.

I wish to grant access to my dental records to:

_____

Print name of parent or guardian and relationship

_____

Print name of parent or guardian and relationship

_____

Print name of patient

_____

Signature of patient and date

OUR APPOINTMENT POLICY

We are pleased that you have chosen Mark J Halboth DDS PC . for the entire family for your dental needs. To better serve you, we have provided specific prescheduled appointment times for you.

These times are held for you so we can do our best to make sure your visits are thorough and efficient. If in the future you can not make your appointment, please have the courtesy to call and reschedule. We do require a 24 hour notice.

Failure to notify us will result in a $50.00 missed appointment fee.

Patient Signature_____ Date _____

Awesome Dental

Payment Policy, Financial Arrangements and Insurance Responsibility

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

In an effort to control our dental expenses, payment is due at the time services are provided unless payment arrangements have been approved in advance. We accept cash, checks, and money orders, Master Card or Visa. Dental work which takes a few weeks to complete (dentures, crowns, and bridge work, etc.) requires a down payment when the work is started (50% of the total fee). Payments may be made while the work is in progress, but the total fee is expected to be paid in full when the work is completed unless financial arrangements are discussed prior to treatment. Care Credit financing is also available to allow extended payment plans which may be interest free for up to one year.

If you have dental insurance we are anxious to help you receive your maximum allowable benefits. We must emphasize that as dental care providers, our relationship is with you, and not your insurance company.. All charges are your responsibility from the date the services are rendered. Due to ongoing insurance policy changes, it is no longer an easy task to monitor the vast number of policies. Insurance companies offer many different types of dental coverage. Most of the plans require the patient to pay an annual deductible. This is the amount deducted before the insurance company will begin to pay. Your policy will have a co-insurance. This is the percentage portion not covered by your insurance—the part payable by you. Some companies have a co-pay which is an amount due at each visit. If a service is not covered by the insurance plan, by law, the patient is usually responsible.

The billing staff will charge you according to the information provided by your insurance company. When we receive payment, if your insurance company has determined you owe additional charges, as required by law, you will be billed. All balances must be paid promptly. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact us for assistance in the management of your account. **I agree to pay for all charges not covered by my insurance.**

Return Checks are subject to a $35.00 banking fee.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I have read and understand the above information and agree to pay as stated above. **Mark J Halboth DDS**

_____ _____

Signature **Date**

_____ _____

Witnessed **Date**