DAVID SCHMIDT, D.D.S.

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Child

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

If Full Time Student School Name _____

Whom may we thank for referring you? _____

Person Responsible for Account _____ Relationship to Patient _____

PRIMARY INSURANCE

Insurance Company Name: _____ Phone: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's ID #: _____ Insured's Date of Birth: _____

Insured's Employer: _____ Employer's Phone #: _____

Work Address: _____

Group # _____ Effective Date: _____

SECONDARY INSURANCE

Insurance Company Name: _____ Phone: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's ID #: _____ Insured's Date of Birth: _____

Insured's Employer: _____ Employer's Phone #: _____

Work Address: _____

Group # _____ Effective Date: _____

AUTHORIZATION

I have reviewed the information on the front and back of this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this 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.

I grant permission to David Schmidt, D.D.S., to use my name, photograph, video, audio recording and/or testimonial in marketing or teaching materials used for his dental practice, including Dr. Schmidt's website. Check the box no ❑ if you do not agree.

Signature: _____ Date: _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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 will receive. Thank you for answering the following questions.

DENTAL HISTORY

What would you like us to do today?_____ Are you in dental discomfort today? _____
Former Dentist_____
Date of last dental care _____ Date of last x-rays_____
Check (✓) if you have had problems with any of the following:

❑ Bad breath
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between teeth
❑ Grinding or clenching teeth
❑ Loose teeth or broken fillings
o Periodontal (gum) treatment
o Sensitivity to cold
o Sensitivity to hot
❑ Sensitivity to sweets
❑ Sensitivity when biting
❑ Sores or growths in mouth

How often do you brush?_____ How often do you floss or use toothpicks? _____
How do you feel about the appearance of your teeth? _____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N
Other information about your dental health or previous treatment. _____

Notify in case of emergency_____ **Home Phone** _____
Cell Phone _____ **Business Phone** _____
Email _____

MEDICAL HISTORY

Physician's name_____ Phone _____
Date of last visit_____ Have you had any serious illness or operations? ❑ Y ❑ N
If yes, describe _____
Are you currently under physician care? ❑ Y ❑ N If yes, describe _____
Have you ever had a blood transfusion? ❑ Y ❑ N If yes, describe _____
Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N
Women: Are you pregnant or trying to get pregnant? ❑ Y ❑ N Nursing ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N
Please check (✓) if you have had any of the following:

❑ AIDS/HIV Positive
❑ Anaphylaxis
❑ Anemia
❑ Arthritis, Rheumatism
❑ Artificial Heart Valves
❑ Artificial Joints
❑ Asthma
❑ Back problems
❑ Blood disease
❑ Cancer
❑ Chemical dependency
❑ Chemotherapy
❑ Circulatory problems
❑ Cortisone treatments
❑ Cough, persistent
❑ Cough up blood
❑ Diabetes
❑ Epilepsy
❑ Fainting
❑ Food allergies
❑ Glaucoma
❑ Headaches
❑ Heart murmur
❑ Heart problems
Describe_____
❑ Hemophilia/Abnormal Bleeding
❑ Herpes
❑ Hepatitis
❑ High blood pressure
❑ Jaw pain
❑ Kidney disease or malfunction
❑ Latex allergy
❑ Mitral valve prolapse
❑ Nervous problems
❑ Pacemaker/Heart surgery
❑ Psychiatric care
❑ Rapid weight gain or loss
❑ Radiation treatment
❑ Recreational drugs
❑ Respiratory disease
❑ Rheumatic/Scarlet fever
❑ Shingles
❑ Shortness of breath
❑ Skin rash
❑ Spina Bifida
❑ Stroke
❑ Surgical implant
❑ Swelling of feet or ankles
❑ Thyroid disease or malfunction
❑ Tobacco habit
❑ Tonsillitis
❑ Tuberculosis
❑ Ulcer/Colitis
❑ Venereal disease

What medication, vitamins or herbal supplements are you taking?

_____
_____

Does patient have drug allergies? If yes, list all:

_____
_____

MEDICAL HISTORY UPDATE – (For Office Use Only)

Have there been any changes in your health since your last dental appointment? Yes_____ No_____
If yes, for what condition? _____
What medication, vitamins or herbal supplements are you taking? _____
_____

Patient Signature: _____ Date:_____

DAVID SCHMIDT D.D.S PLLC,

3060 PACKARD ROAD – YPSILANTI, MI 48197
TEL: 734-485-2200- EMAIL: APPOINTMENT@YPSILANTIDENTIST.COM

FINANCIAL POLICY & CREDIT CARD AUTHORIZATION FORM

Thank you for choosing **David Schmidt D.D.S.** Our primary mission is to deliver the best and most comprehensive dental care available. Our fees are based on the quality materials we use and the time, effort and skill required in performing your treatment. They are reasonable and customary to our area. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering payment options. We accept cash, check, Visa, MasterCard, American Express or Discover Card. For extensive cases/treatment we offer usage of a convenient Monthly Payment Option from CareCredit Healthcare Credit Card or Lending Point. This option allows you to pay overtime with no annual fees or pre-payment penalties

Payment is due at the time services are rendered unless alternate arrangements have been made in advance with the office manager. We require an initial deposit for any treatment involving a laboratory. For patients with PPO dental insurances, as an out of network provider with all plans except for Delta Dental Premier, Blue Cross Blue Shield, and Cigna, we are happy to work with your carrier to maximize your benefit and directly bill them electronically for costs of your treatment. Your *estimated* copayments are due on the date of service.

For <u>all</u> patients with dental insurance, we require a credit card to be kept on file for any balances unpaid by the insurance. Once we receive payment from your dental insurance carrier, if there is any balance remaining, we will charge the credit card on file.

While most PPO dental insurances do directly reimburse the dentist, some may only remit payment to the patient. In this case, the patient is responsible for providing payment in full to the office at the time of service and we will file a claim on your behalf to your carrier for reimbursement.

I understand that payment is expected at the time of service. I hereby agree to pay and guarantee payment in full of any and all charges for services rendered, unless otherwise stated in the investment options.
In the event of a missed appointment or a cancellation of an appointment without 24 hours' notice, there will be a charge of $50.00 applied to your account. This cancelation fee is not covered by your insurance; it is your responsibility and must be paid prior to rescheduling the missed or canceled appointment.

I understand that my dental insurance may only pay a portion of my treatment cost and that my portion is due no later than the time of treatment, unless otherwise stated in the investment options.
The amount that the insurance company states they will pay is only an *estimate* that has been obtained over the telephone or via their website.

If the insurance company pays a lesser amount or denies my claim, I will receive a statement to that effect, and it will be my responsibility to pay the difference. If the insurance company pays more, I will be sent a refund for the difference.

I hereby agree that should my dental and/or medical benefits provider not respond to Dr. Schmidt within 45 days from the date of service; I will assume immediate responsibility for the payment and remit the balance owed in full, unless otherwise stated in the investment options.

I hereby authorize payment direction to Dr. Schmidt of all dental and or/medical benefits otherwise payable to the policyholder. I also authorize Dr. Schmidt and his designees to release information to my insurance company.
I hereby agree that should my account need to be forwarded to a collection agency for collection, that any attorney and court fees incurred by Dr. Schmidt in the collection process will also be guaranteed by me.

Upon any credit card charges processed, please send me a courtesy notification by:

(CHECK ONE) _____ Phone _____ E-Mail _____Mailed Receipt

NOTE: We do not wait for a verbal, text or email approval, as this form serves as the authorization.

Patient Name: _____

Cardholder Name: _____; Relationship: _____

Billing Address: _____

Card #: _____ Exp Date: _____/_____ Sec Code: _____

Cardholder Signature: _____ Date: ____/____/_____

*Is this an employer funded HealthSavings or Flexible Spending card? _____YES _____NO

Should this card be used for Other family members? _____YES _____NO

Name of Patient (First and Last)	Date of Birth

○ **I prefer not to leave a credit card authorization on file. I understand at the time of treatment all copayments and payments must be paid.**

Patient Name

_____

Print Date

Responsible Party

_____

Print Date

Responsible Party

_____

Signature

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) requires that this office complies with certain rules regarding the maintenance of the privacy of your health information that we have collected and will collect in the future.

To comply with one of HIPAA's new requirements, 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 acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any or 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 a referral to or 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 today 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 Signature Patient Name (please print)

Date _____.

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_____.

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 Signature Patient Name (please print)

_____

Date