Dream Dental Group
relax, we care

www.dreamdentalgroup.com

Registration Form

Name:_____ Date:_____

Address:_____

_____

Email Address:_____

Would you like to receive appointment reminders via email/text? Y/N

Phone Number:

HOME:_____

CELL:_____

WORK:_____

How did you hear about us?_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

FINANCIAL POLICY
DREAM DENTAL GROUP

Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility as a Dream Dental Group patient.

1. ALL PATIENTS MUST COMPLETE A PATIENT REGISTRATION FORM BEFORE BEING SEEN.
2. FULL PAYMENT OF CO-PAYS IS DUE AT TIME OF SERVICE.
3. WE ACCEPT CASH, CHECKS, VISA, AND MASTERCARD.

Adult patients are responsible for full payment at time of service.

The adult accompanying a minor patient is responsible for full payment for the minor at time of service.

The parents or guardian of an unaccompanied minor are responsible for full payment at time of service.

Dream Dental Group provides insurance billing as a COURTESY to our patients. The patient portion of the dental service is estimated and due, in full, at time of service. This amount may be subject to adjustment when the dental service claims are adjudicated by the insurance company. In addition, most insurance companies have annual limitations for the amount of dental services that can be reimbursed each year. If you or your family exceed these limitations, in any plan year, you will be responsible for the full amount of dental services that exceed the plan limitation. The patient is responsible for monitoring the amount of remaining benefits for any annual benefit period.

The claims we submit to the insurance companies indicate that you have assigned benefits to Dream Dental Group. However, if you are paid by the insurance company, you then become responsible for the total account balance and payment will be expected immediately.

If you or your family has more than one insurance program, we will assist you in obtaining the maximum benefits available. You, as a patient, are responsible for any charges that are not covered by your insurance company.

Delinquent Payments: Any balance of 90 days or more is considered delinquent and may be sent to our attorneys for collection. Once the patient has received three billing statements and has been contacted by phone, Dream Dental Group reserves the right to charge any audited and documented delinquent balance to the patient's existing credit card on file. By signing this document I am authorizing Dream Dental Group to make these charges. This authority will remain in effect until Dream Dental Group PLLC is notified by me in writing to cancel it in such time as to afford Dream Dental Group PLLC and the credit card company reasonable opportunity to act upon it. I will not dispute the Dream Dental Group PLLC charge with my credit card issuer as the amount in question was for treatment rendered prior to my cancelling my account in the manner required. I agree that if I have any problems or questions regarding my account I will contact Dream Dental Group at 248.363.7121.

We request 48 hours notice if you cannot make an appointment. A $50.00 FAILED APPOINTMENT CHARGE may be applied for failed appointment and those cancelled with less that 48 hour notice.

Thank you for reading and understanding our Financial Policy.

Print Name_____

Signature _____ Date _____

Patrick Qatsha, DDS
Leyvee Cabanilla Jacobs, DDS, MSD
Angela Rassam, DDS
9600 Commerce Rd, Commerce Twp, MI 48382 O: 248.363.7121 | F:248.363.7263

FAILED APPOINTMENT POLICY

LATE CANCELLATIONS AND NO-SHOWS

In order to continue to provide quality care Dream Dental Group is enforcing our appointment/cancellation policy. We ask our patients to courteously call our office promptly if an appointment needs to canceled or rescheduled. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely dental care.

A Failed Appointment will result in a **$50 fee** being charged to your account. This fee will not be covered by your insurance company

- A Failed Appointment is defined as the following:
  - Cancelling or Rescheduling an appointment less than 48 hours in advance of your appointment.
  - No-Show, i.e., missing your appointment without notice to our office.
  - Arriving 15 minutes or more past your appointment time.
  - *You will not be able to schedule future appointments until all balances and fees are paid.*

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager to discuss.

I have read and understand the Cancellation/No-Show Policy and agree to its terms.

Patient: _____ Date _____/_____/_____
Signature Parent/Legal Guardian — Month Day Year

Witness: _____ Date _____/_____/_____
Signature — Month Day Year

Patrick Qatsha, DDS
Leyvee Cabanilla Jacobs, DDS, MSD
Angela Rassam, DDS
9600 Commerce Rd, Commerce Twp, MI 48382 O: 248.363.7121 | F:248.363.7263

Authorization for Release of Dental Information to Family Member or Friend Without Power of Attorney

I, _____(patient), hereby give the following person(s) authorization to obtain information regarding my (check all that apply):

- ☐ Confirm appointments/leave messages
- ☐ Radiographic images
- ☐ Billing Information
- ☐ All protected health/dental information
- ☐ All of the Above

Person 1: _____
Person 2: _____
Person 3: _____
Person 4: _____

Dream Dental Group's privacy policy was made available to me.

Patient: _____ Date _____/_____/_____
Signature Month Day Year

Witness: _____ Date _____/_____/_____
Signature Month Day Year