



PATIENT INFORMATION

Date _____

Patient's Name _____
LAST FIRST MIDDLE

Preferred Name _____

Address _____
STREET CITY ZIP

Home Phone _____

Cell Phone _____

Work Phone _____

Social Security No. _____

Birthdate _____

How did you learn about our office? _____

If from a friend or relative, his/her name _____

RESPONSIBLE PARTY INFORMATION

Name _____
LAST FIRST MIDDLE

Marital Status _____

Residence _____
STREET CITY STATE ZIP How Long _____

Previous Address (if > 3 years) _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

Home Phone _____

Cell Phone _____

Work Phone _____

Social Security No. _____

Birthdate _____

Relationship to Patient _____

Employer _____ Occupation _____ No. of Years Employed _____

Spouse's Name _____
LAST FIRST MIDDLE

Social Security No. _____

Birthdate _____

Relationship to Patient _____

Employer _____ Occupation _____ No. of Years Employed _____

INSURANCE INFORMATION

Insured's Name _____

Insured's Social Security No. _____

Insurance Company _____

Group Number _____ Local No. _____

Insur.Co. Address _____

Do you have dual coverage? ☐ YES ☐ NO If Yes - _____

Insured's Name _____

Insured's Social Security No. _____

Insurance Company _____

Group Number _____ Local No. _____

Insur.Co. Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____ Phone _____

In order to protect my dental health, I authorize you to contact me by phone as needed. If I am on the national or state Do Not Call Registry, this authorization applies to time guidelines beyond those stated in the Do Not Call Registry(s).

CONSENT The undersigned hereby authorized Doctor to take images, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the patient indicated on this form, and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility of payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over sixty (60) days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

I understand that where appropriate, credit bureau reports may be obtained

Signature (Parent's signature if minor) _____

Date _____

Updates (date & initial) _____

Name: _____ Birth Date: _____

| | Y | N | If yes, please explain: |
|--|--------------------------|--------------------------|-------------------------|
| Are you under a physician's care now? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you ever been hospitalized or had a major operation? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you ever needed to pre-med before an appointment? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Are you taking any medications, drugs, or supplements? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you take or have you ever taken Phen-Fen or Redux? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you ever taken Fosamax, Actonel, or any other medications containing bisphosphonates? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Are you on a special diet? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> | |

•Are you allergic to any of the following?

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Penicillin ☐ Sulfa Drugs
☐ Other _____ ☐ No Known Medical Allergies

•Women: Are you

Pregnant or trying to get pregnant? ☐ Y ☐ N Taking oral contraceptives? ☐ Y ☐ N Nursing? ☐ Y ☐ N

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

| | Y | N | | Y | N | | Y | N | | Y | N |
|---------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|
| AIDS/HIV | <input type="checkbox"/> | <input type="checkbox"/> | Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B or C | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Alzheimer's | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | Renal Dialysis | <input type="checkbox"/> | <input type="checkbox"/> |
| Anaphylaxis | <input type="checkbox"/> | <input type="checkbox"/> | Eating Disorder | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Hives or Rash | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis/Gout | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | Seizures/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst | <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | STIs | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Joint | <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Shingles | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Cough | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Dry Mouth | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Spina Bifida | <input type="checkbox"/> | <input type="checkbox"/> |
| Breathing Problems | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Intestinal Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Bruise Easily | <input type="checkbox"/> | <input type="checkbox"/> | Genital Herpes | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Mental Health Concerns | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of Limbs | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | Tonsilitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold sore/Fever Blisters | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or Growths | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Heart Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease or Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joints | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone Treatment | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Parathyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | If you have any other medical conditions, please list them in the comments. | | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment | <input type="checkbox"/> | <input type="checkbox"/> | | | |

If you have diabetes, what was your most recent A1C and/or FBG? _____

Comments: _____

Patient/Guardian Signature _____ Date _____

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 this patient's health. It is my responsibility to inform the office of any medical changes.



PREFERRED DENTAL GROUP

38000 Ann Arbor Trail, Livonia MI 48150

734-591-3636

Revised Date: 2 May 2018

MEMORANDUM FOR: Record

SUBJECT: Patient Acknowledgement and Consent Form

1. Effective April 14 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPPA) 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.

To comply with one of HIPPA requirements we will give you a copy of our Notice of Privacy Practices. This notice of Privacy Practices contains the Information that HIPPA requires us to disclose regarding our privacy practice.

Patient Acknowledgement

I acknowledge that a copy of the Notice of Privacy Practice has been made available to me today.

| Patient name | Patient Signature | Date |
|---|-------------------|------|
| FOR OFFICE USE ONLY | | |
| Patient refused to sign. | | |
| The following circumstances prohibited the patient from signing the acknowledgement | | |
| <hr/> | | |
| <hr/> | | |
| An emergency situation prevented the patient from signing the acknowledgement. | | |
| <hr/> | | |
| <hr/> | | |
| Staff Member Name | Staff Signature | Date |

Patient Consent

I consent to your disclosures of my information, which you deem necessary in connection with my treatment.

I understand that such disclosures may not be of the type listed above.

| | | |
|--------------|-------------------|-------|
| <hr/> | <hr/> | <hr/> |
| Patient Name | Patient Signature | Date |



Welcome- to be able to care for you, current information is important. Please update the following and also please indicate your preference.

Please update the following:

Name: _____

Cell Phone number: _____

Email Address: _____