

CHILD ACQUAINTANCE INFORMATION

					Dete	
Childh Nama	1				Date Preferred Name	
Child's Name	LAST	F	IRST	MIDDLE		
Address STREET			env env	ZIP	Home Phone	
Birthday					Hobby or Sport	t
FAVORITE Toy		_			Fictional Character	
arent's or Guardian's Name			•			•
low did you learn about our office?_				If from a friend or	relative, his/her name)
		RESPONSIE	LE PARTY	NFORMATION		
Father's Name					Maritial Status	s .
	LAST		FIRST	MIDDLE		How Long
Residence street			CITY	STATE	ZIP	_ riuw cong
Previous Address (if > 3 years)_		STREET		CITY	STATE	ZIP
Mailing Address		OTREE	,	il.		
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		Ceil Ph			Work Phone	
Social Security No.			unation		No of Ves	ars Employed
Employer			wham.			
Mother's Name	LAST -		FIRST	MIDDLE	Melitial gratu	IS
Residence STREET	*******			STATE	516	How Long
Previous Address (if > 3 years)		· • •	CITY	, SINIE	LiF	
		STREET		CITY	STATE	ZIP
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Are you under a physician	's ca	ire r	iow?	*********		1					XXXIII P. 10.00		H-150
lave you ever been hospitalized or had a major operation?		 m?	H	-									
						=							
Have you ever needed to pre-med before an appointment?			H	<u>၂</u>									
	Are you taking any medications, drugs, or supplements?			<u> </u>	_								
Do you take or have you e				•	L								
Have you ever taken Fosa					$ \Gamma $	1							
medications containing bi	<u> </u>	ospi	ionates?		├	_ 							
Are you on a special diet?					닏	<u> </u>				* *************************************			
Do you use tobacco?					L	<u>_</u>				***************************************			
Do you use controlled sub					<u>L</u>								
Are you allergic to any of	the	foll	owing?										
Acrylic Aspirin Other Women: Are you			Codeine Late				Local Anesthetics [Peni		Known Medical Allergies			
Pregnant or trying to get p	regr	ant	? Y N Takinı	g ora	al co	onti	raceptives? Y N			Nursing? Y N	,		
•Do you have or have you	har	lanı	of the following?										
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	Y	N		Υ	N	,		Y	N		 Y	' N	
AIDS/HIV		<u></u>	Drug Addiction	Щ		-	Hepatitis B or C		Щ	Recent Weight Loss	╄	╬	_
Alzheimer's			Easily Winded	Щ	Щ		Herpes		\perp	Renal Dialysis	╄	╬	_
Anaphylaxis			Eating Disorder	\blacksquare	Н		High Blood Pressure	Щ	\square	Rheumatic Fever	▙	₩	4
Anemia			Emphysema	\sqcup	닏	-	High Cholesterol		ᆸ	Rheumatism	-	╁┾	_
Angina		Щ	Epìlepsy	\blacksquare	Щ		Hives or Rash			Scarlet Fever	╄	╬	-
Arthritis/Gout	Ш	Щ	Excessive Bleeding	$\downarrow \downarrow$	닏		Hypoglycemia		Щ	Seizures/Convulsions	╄	╀	_
Artificial Heart Valve		-	Excessive Thirst	-	-		rregular Heartbeat		-	STIs .	_	╬	
Artificial Joint	-		Fainting Spells	\dashv	-	-	laundice		\blacksquare	Shingles	-	╬	24.00
Asthma	<u> </u>	-	Frequent Cough	H	-	4	Kidney Problems			Sickle Cell Disease	-	╬	·
Blood Disease	Н		Frequent Diarrhea	\dashv	-		Leukemla		\blacksquare	Sinus Trouble	╄	╬	m
Blood Transfusion			Frequent Dry Mouth		<u> </u>	י נ	Liver Disease		Ш	Spina Bifida	<u> </u>	JL	
Breathing Problems		Ш	Frequent Headaches			I	Low Blood Pressure			Stomach/Intestinal Disease		JL]
Bruise Easily			Genital Herpes				Lung Disease		Ш	Stroke	L	丄	_
Cancer			Glaucoma			1	Mental Health Concerns		Ш	Swelling of Limbs	L	41	_
Chemotherapy			Hay Fever	Ц	Ш		Mitral Valve Prolapse			Thyroid Disease	lacksquare	╀	
Chest Pains			Heart Attack	Щ			Osteoporosis		1	Tonsilitis	<u> </u>	╀	NOSIF
Cold sore/Fever Blisters	Ш		Heart Murmur]	Pacemaker			Tumors or Growths	L	JL	
Congenital Heart Disorder			Heart Disease or Heart Trouble				Pain in Jaw Joints			Ulcers][_
Cortisone Treatment			Hemophilia	\blacksquare		4	Parathyroid Disease			If you have any other me			
Diabetes			Hepatitis A		<u></u>]	Radiation Treatment			conditions, please list th the comments.	em i	in	
If you have diabetes, wi													
COMMICILIA													_
D-11-11/0-11 - 01-	4.	•								Data			_
Patient/Guardian Signa	ture	3								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.

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 pro	phibited the patient from signing the ackno	owledgement
An emergency situation prevente	d the patient from signing the acknowleds	gement.
		,,,,

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.

Patient Name	Patlent 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:	
•	<i>:</i>
Cell Phone number: _	
	,