PATIENT INFORMATION

TODAY'S DATE:

PLEASE COMPLETE ALL THE REQUESTED INFORMATION IN INK. **PLEASE PRINT**

NAME: ______________________________
Last *First* *Middle*

ADDRESS: ______________________________
Number *Street* *Apt# or PO Box*

____
City, State, Zip

SSN#: ______________ DL#: ______________

HOME PHONE: ______________

CELL PHONE: ______________

BIRTHDATE: ______________

☐ MARRIED ☐ SINGLE ☐ MINOR

☐ MALE ☐ FEMALE

PERSON RESPONSIBLE FOR THE ACCOUNT

NAME: ______________________________
Last *First* *Middle*

ADDRESS: ______________________________
Number *Street* *Apt# or PO Box*

____
City, State, Zip

SSN#: ______________ DL# ______________

EMPLOYER: ______________ PHONE: ______________

ADDRESS: ______________________________
Number *Street* *Apt# or PO Box*

____
City, State, Zip

RELATIONSHIP TO PATIENT: ______________

HOME PHONE: ______________

BIRTHDATE: ______________

INSURANCE CO: ______________

CONTRACT #: ______________

GROUP #: ______________

PLEASE HAVE YOUR INSURANCE CARD FOR US TO COPY

EMERGENCY CONTACT

NAME: ______________ PHONE: ______________ RELATIONSHIP TO PATIENT: ______________

AUTHORIZATION

I hearby authorize direct payment to Perry Dental PLC of any group insurance benefits otherwise payable to me. I accept full financial responsibility for all charges incurred at the time of service, regardless of any existing contract with my insurance Company.

I authorize the dental staff to administer any medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this form and the dental / medical history are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical history and other information about my dental treatment to third party payors and/or other health professionals.

SERVICE CHARGE

If I do not pay the entire balance on my account within 90 days, a 1% monthly finance charge will be added to my account. In the event I default on payments to my account, I will be responsible for any legal interest due, as well as any legal costs/fees incurred during the collection of the balance due.

X ______________________________
Patient or Responsible party **Date**

MINOR / CHILD CONSENT

As legal guardian of the minor listed above, I hearby request and authorize the dental staff to perform all necessary dental services, including but not limited to X-rays, and administration of anesthetics, which are deemed advisable by the dentist, whether or not I am present when treatment is rendered.

X ______________________________
Patient or Responsible party **Date**

PERRY DENTAL

MEDICAL HISTORY

Who is your personal physician? ______________________ Office location: ______________

Date of last complete physical exam? ______________________ Doctor's Phone: ______________

Please draw a circle around any of the following which you have had or have at present.

Heart Disease or Condition	Rheumatic Fever	Asthma	Hepatitis	Venereal Disease (Syphillis,
Angina Pectoris	Stroke	Hay Fever	Thyroid Disease	Gonorrhea)
High Blood Pressure	Hemophilia	Emphysema	Glaucoma	Drug Addiction
Shortness of Breath	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures	Psychiatric Treatment
Swollen Ankles	Anemia	Diabetes	Fainting or Dizzy	Cancer
Artificial Heart Valve	Blood Transfusion	Ulcers	Spells	Radiation Therapy
Congenital Heart Disease	Sickle Cell Disease	Kidney Trouble	AIDS	Chemotherapy
Heart Murmur	Arthritis	Liver Disease	HIV Positive	Implant Prostheses
		Jaundice (Other than at birth)	Cold Sores	Unexplained Weight Loss
			Genital Herpes	Osteoporosis Therapy

FOR THE FOLLOWING QUESTIONS PLEASE CIRCLE YES OR NO

1. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR?	NO	YES	*If YES, what are you being treated for?*
2. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS?	NO	YES	*If YES, please list*
3. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS?	NO	YES	*If YES, please list*
4. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?	NO	YES	*If YES, please explain*
5. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT?	NO	YES	*If YES, please explain*
6. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE?	NO	YES	*If YES, please list*
7. HAVE YOU BEEN TOLD YOU ARE NOT ELIGIBLE TO DONATE BLOOD?	NO	YES	*If YES, please explain*
8. DO YOU USE TOBACCO PRODUCTS?	NO	YES	*If YES, please circle* *Cigarettes Cigars Pipe Smokeless*
9. WOMEN: ARE YOU PREGNANT?	NO	YES	*If YES, please circle* ***TRIMESTER 1 2 3***

SIGNATURE OF PATIENT *(OR LEGAL GUARDIAN IF PATIENT IS A MINOR)* **X**	DATE **X**

DENTIST'S COMMENTS

Signature: Date:

MEDICAL UPDATES

Date	Exceptions NONE ☐	BP	Signature
Date	Exceptions NONE ☐	BP	Signature
Date	Exceptions NONE ☐	BP	Signature
Date	Exceptions NONE ☐	BP	Signature
Date	Exceptions NONE ☐	BP	Signature
Date	Exceptions NONE ☐	BP	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 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 the HIPAA's 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 us (in addition to our attempt to obtain your written acknowledgement, discussed above) to obtain your written consent prior to disclosing any of your 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 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 other dentist or other health care professionals, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordination your treatment.

PATIENT ACKNOWLEDGEMENT

Please sign this form below to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

X ______________________________
Patient Signature (18 or older)/ Legal Guardian
☐**Patient** ☐**Legal Guardian**

X ______________________________
Patient Name printed

X ______________________________
Date

FOR OFFICE USE ONLY:
We attempted to obtain a written acknowledgement of our Notice of Privacy Practices, but acknowledgment couldn't be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other:______________________________

Employee Signature:______________________________ Date:____________________

PATIENT CONSENT

Please sign this form below 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.

X ______________________________
Patient Signature(18or older)/Legal Guardian
☐**Patient** ☐**Legal Guardian**

X ______________________________
Patient Name printed

Date X ______________________________

Perry Dental, PLC

114 N. Main St
PO Box 619
Perry, MI 48872
517.625.4163

Financial / Cancellation Policy

We hope you understand that our credit and collections policies are a necessary part of assuring the financial resources needed to maintain this vital health care facility for our patients and the community.

As a courtesy, we will be glad to bill your dental insurance, it would be understood that this is an agreement between you and your insurance company. ***It is your responsibility to know and understand your insurance.*** Your doctor bill is an agreement between you and your doctor. You are responsible for the payment of your bill, regardless of the status of your insurance claim. *Outstanding account balances require monthly payments of 10% of the balance. Account balances over 90 days will be charged a 1% finance charge monthly.

All charges & co-pays are due at the time of service, unless ***prior*** arrangements have been made.

Insurance companies have a schedule of fees which they will pay. The doctor's fees may be more or less than the schedule of your insurance company. ***You*** are directly responsible for your account, regardless of your insurance schedule.

You will be charged a $60.00 fee if you miss an appointment or cancel without a 24 hour notice. We understand that rare emergency situations may occur, and under those circumstances we can completely understand. It is ***not*** our policy to schedule several patients at the same time; time is specifically reserved for you. Insurance companies do not pay for missed appointments; therefore, the fee will be your responsibility. If you have any further questions, please feel free to discuss them with the front office staff.

AUTHORIZATION:

I hereby authorize Perry Dental PLC to furnish my insurance carrier any information they may need concerning my office visits. I irrevocably assign to the doctor all payments for services rendered. **I understand that I am financially responsible for all charges whether or not covered by my insurance.**

____
Patient Name (printed)

______________________________ ________________
Signature of Responsible Party **Date**
(18 yrs or older)