Patient Registration Form

Patient Name: _____ Preferred Name:_____

Birth Date: _____ Gender: M / F / Other

SS#: _____ Circle One: Married/Single/Widowed/Divorced

Address: _____

(Street) (City, State Zip)

Home Phone: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

Employer Name: _____

Responsible Party if Patient is under 18 years old:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

How did you hear about our studio?: _____

Who to call for an emergency?

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Primary Dental Insurance Information

Company Name: _____ Phone: _____

ID #: _____ Group #: _____

Insured Name: _____ DOB: _____

Insured Employer: _____ Gender: M / F / Other

Relationship to Patient: _____

Secondary Dental Insurance Information

Company Name: _____ Phone: _____

ID #: _____ Group #: _____

Insured Name: _____ DOB: _____

Insured Employer: _____ Gender: M / F / Other

Relationship to Patient: _____

I authorize the release of any medical information necessary to process any claims to the insurance company, and request payment of benefits to 616 Dental Studio. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I agree that the information on this page is correct to the best of my knowledge.

_____ _____

Patient or Parent/Guardian Signature Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. This form is a "friendly" version of what HIPAA is. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPA provides certain rights and protections to you as the patient. Additional information is available from the United States Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is our office policy to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You are to bring any concerns or complaints regarding privacy to the attention of the Office Manager or Doctor.
6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.

I, _____ (print name) do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

(Patient/Guardian Signature) Date

Dr. Marcos Cid, DDS MS
171 Monroe Ave NW Suite 100
Grand Rapids, MI 49503

Dr. Brockton Willey, DDS
736 Stocking Ave NW
Grand Rapids, MI 49504

Phone (616) 214-7865
Fax (616) 328 - 6770
www.616dentalstudio.com

STUDIO

171 Monroe Ave NW
Grand Rapids, MI 49503

736 Stocking Ave NW
Grand Rapids, MI 49504

OFFICE FINANCIAL POLICY

Payment is expected at time of service. We accept cash, check, or credit card. Checks will only be accepted with a valid driver's license. There will be a $25 service charge for a returned check.

We will bill your insurance. We file your claims at no charge. It is the patient's responsibility to provide us with current insurance information.

If any payment from an insurance company becomes 30 days past due, you will be immediately billed for the entire balance.

We will file pre-treatment estimates. Please be aware that some insurance companies may not honor a pre-treatment estimate or may alter it. In all cases it may delay important dental care.

Not all services are covered by insurance. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. The staff can never guarantee your coverage and eligibility.

If your insurance plan denies a service, you will be responsible for the complete charge. We do not base your treatment plan on what your insurance plan does or does not cover. We are working for you, not the insurance company.

Past due accounts may be turned over to a collection agency. Any fees incurred due to this will be added to the outstanding balance. This could include late fees, collection agency fees, court fees, etc.

_____ _____

Signature of Responsible Party Date

STUDIO

171 Monroe Ave NW
Grand Rapids, MI 49503

736 Stocking Ave NW
Grand Rapids, MI 49504

MISSED APPOINTMENT POLICY

Our main concern at 616 Dental Studio is the well-being of our patients. It is a goal for us to provide time for the personal attention each patient deserves. With that being said, when you schedule an appointment a specific amount of time is reserved especially for you.

If for any reason you must cancel of change your appointment, it is important that you give our office at least **24 hours notice**. This allows us to offer that time reserved to another patient who may need treatment.

- **1st missed appointment:** If an appointment is missed or cancelled with the 24 hour window, a phone call will be made reminding you of our policy and the effects of your missed appointment. We also reserve the right to charge you a $25 fee for each hour of appointment time scheduled.

- **2nd missed appointment:** After a second missed appointment, a letter will be sent to your home with a copy of the signed missed appointment policy. Again, we reserve the right to charge a $25 fee for each hour of appointment time scheduled. This fee must be paid prior to scheduling any further appointments.

- **3rd missed appointment:** If you fail to keep 3 appointments you will receive a dismissal letter from the practice.

Late arrival: If you arrive 15 or more minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their scheduled appointment time. If this happens it will be considered a missed appointment.

I have read the policy above. I understand and agree to abide by the listed terms.

_____ _____

Signature of Responsible Party Date

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )
Address: *Mailing address*
City: State: Zip:
Occupation: Height: Weight: Date of Birth: Sex:
SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )
If you are completing this form for another person, what is your relationship to that person?
Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?
Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )
Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?
Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:	☐	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments: