DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

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Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date(s) _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin	☐ Sulfa
☐ Barbiturates (Sleeping pills)	☐ Latex _____
☐ Codeine	☐ Other _____
☐ Local Anesthetic	_____
☐ Penicillin	

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

David J. Powell, D.D.S.
2020 Chesley Sterling Heights MI 48310
586 979 0300

Welcome to our practice! We appreciate the trust you have placed in us. One of our primary concerns will be to make you feel comfortable in our office.

If at any time you have any questions or are unhappy about treatment, fee, or service, feel free to discuss this with us candidly. We would appreciate it because we want to avoid any misunderstanding. We are interested in developing a long-term, mutually satisfying relationship, which will enable and encourage you to maintain your dental health.

Treatment:
In order to prevent dental disease, the active disease must be evaluated and eliminated. Therefore, we must have a complete picture of your present oral health conditions, as well as insight into your dental and medical history. We will make a thorough evaluation of existing and potential problems, taking the necessary x-rays and examining the oral tissue for decay and gum/bone disease.

Insurance:
We will be happy to work with any insurance company that allows you to choose your own dentist. Your insurance policy is an agreement between you, your employer and the insurance company. We will submit all claims for procedures performed in this office. In some cases we may even be able to estimate how much your insurance will contribute financially toward your dental treatment. Please remember that this is just an estimate, your insurance company makes all final decisions on payment. If you disagree with the claim payment, please refer to your plan booklet. You are responsible for any and all fees regardless of your insurance decisions.

Appointments:
You will find that we respect our patient's time and make every effort to remain on schedule. We try to complete treatment in as few visits as possible. Because we are considerate of our patient's time, we have found that they are, likewise considerate of our time. A missed appointment is a loss for everyone. We require 24 hours notice if an appointment must be changed so we may offer it to another patient. A $50.00 fee will be incurred for a missed appointment without proper notice.

Privacy-
Our office upholds and exceeds minimum requirements set forth by the Health Insurance Portability and Accountability Act (HIPPA). Please review enclosed notice of how your health information may be used and disclosed. Your privacy is important to us.

Payment Plans:
We feel it is important to discuss our examination findings with you, make recommendations for treatment and discuss in advance what your out of pocket expense will be. If required, financial arrangements are available. Feel free to discuss this with us at any time. Your signature here is your authorization for David J. Powell, D.D.S. or his representative to use your credit card account (MasterCard, Visa, Discovery or any other account) for payment. Any Unpaid balances may be subject to a service charge and or debt collection expense.

I have read and understand the above and give consent to begin treatment for and agree to be financially responsible

_____ **SIGNATURE (Responsible party)** _____**DATE**

Acknowledgement of Receipt of Notice of Privacy Practices- I have Received or Reviewed the Notice of Privacy Practices

_____ _____**SIGNATURE (Responsible party)** _____**DATE**

_____**PRINT NAME**