# MEDICAL HISTORY

**PATIENT NAME**_____ Date of Birth _____

Please update your phone numbers _____

If you would like us to email you, provide email address _____

Are you in good health _____ Are you presently under the care of a physician _____ If so, please give the reason(s) for treatment _____

_____

Physician's name and phone _____ Date of last physical exam_____

Are you taking any kind of medication (prescribed or non-prescribed) at this time _____ If so, please give the name(s) of the medicine(s) and the reason(s) for taking them _____

_____

**CIRCLE ANY ILLNESS or CONDITION YOU HAVE OR HAVE EVER HAD**

| | | | | |
|---|---|---|---|---|
| Alcoholism | Cancer | Head/Neck Injuries | Narcotic/Drug Dependency | |
| Allergies | Diabetes | Herpes | Rheumatic Fever | |
| Anemia | Epilepsy | Hepatitis | Shingles | TMJ |
| Asthma | Emphysema | Immunodeficiency | Sinusitis | Ulcers |
| Arthritis | Heart Murmur | Kidney or Liver | Stroke | HPV |
| Angina | Heart trouble | Mental | STD | Other |
| Blood pressure | HIV/AIDS | Migraine | Thyroid | |

Explanation of "Other"_____

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING** **Latex** **Penicillin**

Aspirin/Ibuprofen Sedatives **Other Antibiotics** **List other allergies** _____

Bleach Local Anesthetic _____

Do you take insulin _____ **Do you take blood thinning medication _____** _____

**Have you ever had any trouble with prolonged bleeding after surgery _____** _____

**Are you currently taking or have you previously taken bisphosphonate medications such as Fosamax, Actonel, Zometa or Boniva within the past twelve years _____**

Do you have a heart pacemaker _____ Do you have any prosthetic appliance (i.e., hip, joint, knee replacement) _____

Do you smoke/vape or use any tobacco products _____ Have you ever been vaccinated for HPV _____

Is there any other information that should be known about your health _____ If so, please explain _____

_____

Any problems with previous dental visits _____ If so, explain_____

If female, are you pregnant _____

**AUTHORIZATION AND RELEASE**

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing false information can be dangerous to my health. I authorize the release of information including diagnosis and treatment records rendered to me or my dependant to a third party payee and/or healthcare practitioners necessary to process dental insurance. I authorize my insurance carrier to issue payment directly to this office.

**Signed PATIENT or PARENT**_____ **Date**_____

Comment:

# ACCOUNT INFORMATION

**Patient Information**

Patient's Name _____

Street Address_____ City_____ State_____ Zip_____

Mailing Address_____

Email Address_____

Home Phone_____ Cell Phone_____ Work Phone_____

Social Security #_____ Birthdate_____

Employer_____ Occupation_____

Who may we thank for referring you to our office_____

**Person Responsible for Account (If Patient is Under 18)**

Name_____ Birthdate_____ Social Security #_____

**Emergency Information**

Name of nearest relative not living with you_____Phone _____

**Dental Insurance Information**

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Employer_____

Insurance/Subscriber ID#_____Group #_____

Insurance Co. Address_____ Insured's Birthdate_____

*Do you have dual coverage?* Yes No *How long has this policy been in effect*_____

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group #_____ Employer_____

Insurance Co. Address_____

Insured's Employer_____ Insured's Birthdate_____

**Method of Payment**

Fees and estimated co-payments must be paid in full at the time of treatment. Any balance over 90 days will be subject to a 5% charge and statement fees may incur. **Which of the following methods of payment you will be using?**

Cash Check VISA MC Discover

All information written is true and complete. The undersigned agrees to be responsible for all fees (and co-payments) for services rendered in this office for me or my dependents.

**SIGNATURE**_____**DATE**_____

**If dental insurance applies:** Although this office files insurance claims as a service to the patient, we are not a participating provider with all insurance companies. The insurance contact is between the patient and the insurance company. PLEASE NOTE THAT CO-PAYMENTS COLLECTED AT THE TIME OF SERVICE ARE ESTIMATES ONLY AND NOT A GUARANTEE OF PAYMENT. As we have no control over the insurance company's method or amount of payment, any difference of payment is entirely the responsibility of the patient.

**SIGNATURE**_____**DATE**_____

# Patient Acknowledgement and Consent Form

Effective April 14, 2003, the 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 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 of our privacy policy, 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 payment of fees; a third party payer's examination of our records' a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

We may make a referral to or consult with another dentist or other health care professional in connection with providing or coordinating your treatment.

## Patient Acknowledgement

*Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.*
I *acknowledge* that I have today received a copy of the Notice of Privacy Practices.

_____ _____ Date_____
Patient Signature Patient Name (please print)

## Dental Records and Xray Release

I hereby authorize the release of dental records and/or xrays, or copies of such, and request they be transferred to Peninsula Family Dentistry at marquette@peninsuladentists.com.

_____dob:_____ _____ Date_____
Patient Signature Patient Name (please print)

For office use only:
Patient refused to sign.
The following circumstances prohibited the patient from signing the Acknowledgement
_____

_____ _____ Date_____
Office Personnel Office Personnel (print name)

## 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.* ***Our office requires this to be signed in order to receive treatment.*** I **consent** to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures will be related to my treatment.

_____ _____ Date_____
Patient Signature Patient Name (please print)