Confidential Patient Information J. Daniel Lewis D.D.S

PLEASE PRINT CLEARLY

PATIENT INFORMATION **TODAYS DATE**_____

NAME: (First) _____M.I._____ (Last)___ _____

I LIKE TO BE CALLED:_____ BIRTHDATE _____ SOCIAL SECURITY / PATIENT ID _____

☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE ☐ CHILD ☐ MALE ☐ FEMALE FULL TIME STUDENT? _____SCHOOL_____

EMAIL_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE HOME _____ WORK PHONE_____ CELL PHONE_____

PATIENT EMPLOYER _____ADDRESS_____OCCUPATION:_____

SPOUSE NAME_____HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR THIS ACCOUNT _____RELATIONSHIP_____

ADDRESS (If different from above) _____

PHONES: HOME _____ WORK _____ CELL _____

NAME AND ADDRESS OF EMPLOYER _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED _____

RELATIONSHIP TO PATIENT_____

BIRTHDATE _____

SOCIAL SECURITY / INSURED ID _____/_____/_____

EMPLOYER _____

ADDRESS _____

WORK PHONE _____

INSURANCE COMPANY

NAME_____

GROUP # _____

INSURANCE CO ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE_____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED _____

RELATIONSHIP TO PATIENT_____

BIRTHDATE _____

SOCIAL SECURITY / INSURED ID _____/_____/_____

EMPLOYER _____

ADDRESS _____

WORK PHONE _____

INSURANCE COMPANY

NAME_____

GROUP # _____

INSURANCE CO ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE_____

DENTAL HISTORY

What is the nature of today's visit? ☐ Exam ☐ Consultation ☐ Emergency _____

Previous dentist _____ Phone _____ City _____

Date of last dental care _____ Last X-rays _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

☐ Bad breath	☐ Bleeding gums	☐ Clicking or popping of the jaw	☐ Trapping food between teeth
☐ Grinding or clenching	☐ Loose or broken fillings	☐ Periodontal treatment	☐ Sensitivity to cold
☐ Sensitivity to sweets	☐ Sensitivity when biting	☐ Sores or growths in the mouth	☐ Sensitivity to hot

How often do you brush? _____ How often do you floss? _____ Do you like your smile? _____ Would you like whiter teeth? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? If so, what? _____

Other information about your dental health or treatment? _____

MEDICAL HISTORY

Physician's Name _____ Phone _____Date of last visit _____

Have you had any serious illness or operations? ☐ Yes ☐ No Describe_____

Are you currently under physician care? ☐Yes ☐No If yes, please describe _____

Have you ever taken Fen-Phen /Redux? ☐Yes ☐ No Have you ever taken osteoporosis medications? ☐Yes ☐ No

Women: Are you pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No Are you using birth control medication? ☐Yes ☐No

Is Fluoride taken? ☐ Yes ☐ No Do you SMOKE or use tobacco? ☐Yes ☐No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Although Dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive or medications we prescribe. Thank you for answering the following questions

Check ☑ if you have had any of the following:

- ☐ AIDS / HIV positive
- ☐ Alcohol/Drug abuse
- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial heart valve
- ☐ Artificial joints
- ☐ Asthma
- ☐ Cancer/Chemotherapy
- ☐ Chemical dependency
- ☐ Circulatory problems
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fosamax/bisphosphonates
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
  Describe _____
- ☐ Hemophilia/abnormal bleeding
- ☐ Herpes
- ☐ Hepatitis- circle A B C
- ☐ High blood pressure
- ☐ Jaw pain
- ☐ Kidney problem
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker / heart surgery
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic/scarlet fever
- ☐ Shingles
- ☐ Thyroid disease/malfunction
- ☐ Tuberculosis
- ☐ Ulcer / Colitis

Allergies to any of the following?

- ☐ Aspirin ☐Codeine
- ☐Dental Anesthetics
- ☐ Erythromycin ☐ Jewelry
- ☐ Latex ☐ Metals
- ☐Penicillin ☐ Tetracycline

IS PATIENT CURRENTLY TAKING ANY MEDICATIONS? IF YES, PLEASE LIST ALL:

_____

_____

Does patient have any drug /material allergies? If yes, please list all:

_____

_____

Complete the following **ONLY** **IF PATIENT IS A MINOR CHILD**–please print clearly-

_____ (___) ___ - ___ (___) ___ - ___

(Mother's First Name) (MI) (Last) (Home Phone Number) (Cell Phone Number)

_____

(Mother's Address) (City) (State) (Zip)

_____ (___) ___ - ___ (___) ___ - ___

(Father's First Name) (MI) (Last) (Home Phone Number) (Cell Phone Number)

_____

(Father's Address) (City) (State) (Zip)

With whom does the child live? ☐ Mother ☐ Father ☐ Both ☐ Other _____
(Please specify)

Date of last visit to the dentist: _____

Has child complained about dental problems? ☐ Yes ☐ No
Does child brush teeth daily? ☐ Yes ☐ No
Does child use floss every day? ☐ Yes ☐ No
Any unhappy dental experiences? ☐ Yes ☐ No

Is fluoride taken in any form? ☐ Yes ☐ No
Any injuries to mouth, teeth, or head? ☐ Yes ☐ No
Any mouth habits, thumb sucking, nail biting, pacifier, mouth breathing, sleeping with a bottle? ☐ Yes ☐ No

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have a change in health. I authorize the use of this signature as "signature on file" for all benefit submissions. I authorize the dentist to release any information necessary to secure payment of benefits. I understand that I am financially responsible for all charges rendered, regardless of and benefit plan. I consent to the use and disclosure of my protected health information to carry out healthcare operations, treatment and payment activities (HIPAA). I have received and or read the HIPPA Privacy Practice.

_____ _____

SIGNATURE of Patient, Parent, Guardian or Personal Representative Date

_____ _____

PRINT name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

OFFICE USE ONLY:
I verbally reviewed the medical/dental information above with the patient named herein. Initials: ____ Date____
Doctors comments:

J.Daniel Lewis D.D.S.

FINANCIAL POLICY

The goal of our office is to provide the highest quality care to ensure optimal health for our patients.
To allow us to continue this service, timely payment is essential.

Payment Options

Full payment is due at time of service. We accept cash, personal checks, credit cards (Visa, Master Card, Discover), and **CareCredit** (our practice financing plan). **CareCredit** allows you to start treatment today, and spread payments over time. There is no application fee and only takes a few minutes to authorize.

Insurance Assisted Patients

We cannot promise or guarantee how your insurance company will pay any claim. The estimated patient co-pay is due in full at time of service. Any difference between estimated and actual insurance payment is due within 30 days. If insurance pays more than estimated, we will refund the difference.

Regarding Insurance

We provide dental insurance billing as a courtesy to our patients. To do so, we need complete billing information to submit your claims accurately. Your insurance policy is a contract between your employer and your insurance company. We are not a party to that contract. Please be aware that what is covered by your policy is dictated by the contract, not what is necessarily in your best interest. In other words, some of the procedures recommended for your dental health may not be covered by certain plans. ALL CO-PAYS AND DEDUCTIBLES WILL BE EXPECTED AT TIME OF SERVICE.

Understanding your coverage can be quite challenging. Each plan is slightly different in its covered services and co-pays. We encourage you to become familiar with your policy exclusions, limitations, deductibles, and required co-pays. Please keep our office informed of any changes in your insurance coverage, so we can serve you better.

Missed Appointments/Cancellation Policy
We value your time and make every effort to provide treatment in a timely manner and in as few visits as necessary. In order to provide the best services to our patients, we require 48 hours notice for cancellations or for re-scheduling your appointment. Because our time is valuable like yours, you may be charged a cancellation fee of $50.00 for any late cancellations or missed appointments.

Please sign below.

I hereby authorize J. Daniel Lewis D.D.S, to release to my insurance company any information required in the course of my dental care. I hereby authorize benefits to be paid directly to J. Daniel Lewis D.D.S with the exception of BCBS. I understand I am responsible for any unpaid balance.

⇨ Signature_____ Date _____

J. Daniel Lewis D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: J. Daniel Lewis D.D.S.

Telephone: (616) 447-7800 Fax: (616) 447-9611

Address: 3350 Grand Ridge Dr NE Grand Rapids MI 49544

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this *Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use* and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Oral Health Risk Factors

Patient's Name: _____

1. Do you smoke or have you EVER smoked? __Yes __No
   (If no, proceed to question 2)

   The amount that you are presently smoking (Check ALL that apply)
   __None (quit smoking completely) __less than 1 pack of cigarettes per day __An occasional cigar
   __An occasional cigarette __1-2 Packs of cigarettes per day __Cigars on a daily/regular basis
   __A few cigarettes per day __ 2 or more packs of cigarettes a day __Occasional pipe smoker
   __A pipe on a daily/regular basis

   If you have quit smoking, when did you quit?
   __Less than 6 months __6 months to a year ago __1 to 3 years ago __Over 3 years ago

   How many years have you or did you smoke?
   __Less than 2 Years __2-5 years __5-10 years __10-20 years __ Over 20 years

2. Do you/ Have you EVER chew/chewed tobacco or use/used snuff or other similar substance?
   Yes __ No _ (If No, proceed to question 3)

   Are you STILL using smokeless tobacco or snuff?
   __Yes __ No
   If no, WHEN did you quit?
   __Less than 6 months __6 months to a year ago __1 to 3 years ago __Over 3 years ago

   How many years did you use or have you used smokeless tobacco?
   __Less than 1 Year __1-2-years __2-5 years __Over 5 years
3. Approximate average amount of alcoholic beverages presently consumed per week**:**
   __None __Less than 1 per week __1-5 drinks __6-11 drinks __11-20 drinks __Over 20 drinks
4. Do you have or have you ever had a substance abuse problem? __Yes __ No
   Describe_____
5. Do you presently use any recreational drugs? __Yes __ No
   List_____
6. Do you have or have you ever had an eating disorder? __Yes __ No
   If Yes, Please specify: _____
7. Do you have or have you ever had any head, neck or mouth piercing(s)? (Other than ears) __Yes __ No
   List_____
8. Do you have or have you ever been informed that you have been infected with an
   Oncogenic strain (possible cancer causing) of the Human Papilloma Virus (HPV)?
   __Yes __ No
9. Please list your history or any family member's history of cancer:
   _____
   _____
10. Other concerns and considerations:
    _____
    _____

CONSENT- To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

Signature_____Date_____
(Parent or guardian, if patient is a minor)

Reviewed By: _____