# Welcome!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible. If you have any questions, or we can help you in any way, please feel free to ask.

## Patient Information (Confidential):

Name _____ (If child, parent/guardian name) _____
Last Name First Name Initial

Birth date _____ Sex _____Age _____ Soc. Sec. # _____

Home Address _____City _____ State _____ Zip _____

Home Phone _____Work Phone _____ Cell Phone _____

Driver's License # _____Email _____

Employer _____Occupation _____ How long there? ____ May we call?___

Employer Address _____City _____ State _____ Zip _____

Spouse's Name (Or other parent/guardian) _____ Soc. Sec. # _____

Spouse's Employer _____ Occupation _____ How long there? ____ May we call?___

Spouse's Employer Address _____City _____ State _____ Zip _____

If patient is a student: Name of School or College _____City/State _____ Full or part time? ___

How did you hear about our practice? _____

## Primary Insurance:

Name of Insured _____

Birth date _____ Relationship to patient _____

Address (if different from patient) _____

_____

Dental Insurance Co. _____ Phone _____

Soc. Sec. # _____Subscriber ID # _____

Group, Contract or Local or Union # _____

## Additional Insurance:

Name of Insured _____

Birth date _____ Relationship to patient _____

Address (if different from patient) _____

_____

Dental Insurance Co. _____ Phone _____

Soc. Sec. # _____ Subscriber ID # _____

Group, Contract or Local or Union # _____

## Copayments:

To accept insurance, we now debit copayments automatically to your credit card. If you would like us to accept your Insurance, please provide credit card information:

☐ MC ☐ Visa ☐ American Express Account # _____ Expiration date _____

☐ Credit Card ☐ Debit Card Name on card _____

## In case of emergency:

Name and City of primary care physician _____

Someone we may contact, not living with you _____ Phone #'s (home, work, cell) _____

## Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card for any unpaid balances, including those after insurance payment. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge.

I have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____
*Patient or Responsible Party*

# Dental History

Patient Name _____ Age _____ Date _____

Reason for seeking care today: _____Exam _____ Cleaning _____ Specific Problem _____
(Please Describe)

*Please check all that apply:*

- ☐ Toothache
- ☐ Broken filling or tooth

Sensitivity to:

- ☐ Cold
- ☐ Hot
- ☐ Sweets
- ☐ Chewing

- ☐ Food catches
- ☐ Loose teeth
- ☐ Floss breaks easily or hurts
- ☐ Bite or teeth have shifted
- ☐ Often bite cheeks
- ☐ Frequent dry mouth
- ☐ Concerned about breath
- ☐ Unhappy with previous dental work
- ☐ Gums bleed
- ☐ Gums tender
- ☐ Growths, sores
- ☐ Cold sores, fever blisters
- ☐ Cracked, chapped lips
- ☐ Bad taste in mouth
- ☐ Sinus problems
- ☐ Mouth breathe - Difficulty breathing through nose
- ☐ Dry or strained eyes
- ☐ Shoulder, neck or headaches
- ☐ Clench or grind teeth
- ☐ Jaw joint pain
- ☐ Clicking or popping of joint
- ☐ Unable to open mouth wide
- ☐ Jaw gets tired easily
- ☐ Hold things between teeth (Pipe, pencil, nails, pins)
- ☐ Bite fingernails
- ☐ Unusual habits with teeth
- ☐ Wore braces
- ☐ Previous gum treatment
- ☐ Previous bite treatment

Would you like whiter teeth? _____ On a scale from 1 to 10, how would you rate your smile (with ten your smile is perfect.)

_____

Please rate 1-10 how anxious you are about dental treatment (1 = totally relaxed) _____

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____

Why did you leave your previous dentist? _____

Did your parents have difficulties with their teeth or dental treatments? _____

# Medical History

Physician's Name _____

City _____ Phone: _____

Have you been hospitalized for any reason? Please describe:

_____

_____

Are you taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed) _____

_____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other? _____

_____

Do you smoke? How much/day? (Yes) / (No) _____

Pregnant? Due date _____ Are you nursing? _____

Are you seeing a physician now or planning to see one for any reason? Please explain:

_____

_____

*Please check all that apply:*

- ☐ Previous injury to head or neck
- ☐ Heart problem
- ☐ Heart Attack
- ☐ Angina, chest pain
- ☐ Heart murmur
- ☐ Scarlet, Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Irregular heartbeat
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Artificial joint
- ☐ Arthritis
- ☐ Diabetes
- ☐ HIV or AIDS
- ☐ Glaucoma
- ☐ Liver problem, jaundice
- ☐ Cirrhosis, Hepatitis
- ☐ Cancer
- ☐ Radiation, Chemotherapy
- ☐ Respiratory problem
- ☐ Bloody, persistent cough
- ☐ Asthma, Emphysema
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Sickle cell
- ☐ Digestive problem, ulcer
- ☐ Thyroid disease
- ☐ Easily winded
- ☐ Bleed or bruise easily
- ☐ Stroke
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Back problem
- ☐ Hives, rash, Herpes
- ☐ Prolonged bleeding
- ☐ Kidney problem
- ☐ Shortness of breath
- ☐ Snoring, sleep apnea
- ☐ Seizures/Epilepsy
- ☐ Fainting or dizzy
- ☐ Unexplained weight loss
- ☐ Chewing tobacco
- ☐ Drug or alcohol addiction
- ☐ 2 or more social drinks/day
- ☐ Anxiety or nervous disorder
- ☐ Insomnia
- ☐ Received any donor organs

Please list any other illnesses or medical condition not checked above: _____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: ☐ Yes ☐ No

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian) _____ Date _____

Dentist' Signature _____ Date _____

# Grosse Pointe Signature Smiles

**20148 Mack Ave. / Grosse Pointe Woods, MI / (313) 884-4014**

## Written Financial Policy

Thank you fo choosing GPSS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable as possible for our patients by offering payment options.

**Payment Options:**

-Cash, check or credit cards such as Visa and Mastercard

-Payment Plans from CareCredit

Allow you to pay overtime some plans have NO interest

Convenient, low monthly payment plans

No annual fees or pre-payment penalties

-Discount to help you save: We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion for treatment plans of $2000 or more. (If you have insurance, we will still process your claim having the benefits go directly to you.)

**Please Note:**

**Requited Deposit:** For larger, more comprehensive treatment plans of $500 or more, a 10% deposit is required to to secure your initial treatment. For plans requiring multiple appointments alternative payment arrangements may be provided.

**Missed Appointment:** A fee of $75 is charge for patient to mess or cancel more than one time in a calendar year without 48-hour notice.

**Overdue Accounts:** A charge of 10% interest on the balance for past accounts of 30 days or more.

**Returned Checks:** A charge of $50 for returned checks.

**Dental Insurance:** We are happy to work with your carrier to maximize your benefit and process your insurance for payment and in doing so we request your estimated time payment be paid when servers are delivered. However, your contract is between your employer and your carrier and we have no control over their decisions. Occasionally benefits are limited and payments are delayed. You're responsible for all financial cost a treatment and if your carrier does not pay in full within 90 days of service we will bill you for the outstanding balance.

**VIP Checkout:** You don't have to wait after your appointment! If you leave a credit card on file to cover any additional fees that may come do once your insurance payment is received we will automatically credit or debit or credit card.

If you have any questions please do not hesitate to ask, we are here to help you get the dentistry you deserve.

| _____ | _____ | _____ |
|---|---|---|
| Date | Patient, Parent or Guardian Signature | Patient Name (please print) |

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement but, in refusing we *will not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Grosse Pointe Signature Smiles. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- □ Cell Phone Confirmation _____
- □ Home Phone Confirmation _____
- □ Work Phone Confirmation_____
- □ Text Message to my Cell Phone
- □ Email Confirmation_____
- □ U. S. Mail / Postcard
- □ **Any of the above**

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA:

- □ Message on Cell Phone
- □ Message on Home Phone
- □ Message on Work Phone
- □ Email Message
- □ U. S. Mail / Postcard
- □ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW DENTAL INFO** VIA:

- □ Phone Message
- □ Text Message
- □ Email
- □ U. S. Mail / Postcard
- □ **Any of the above**
- □ **None of the above**

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**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____

Signature of Privacy Officer