Dental Smiles
of Livonia

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security #: _____ Sex/Gender: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

Were you referred to this clinic? **Y** ☐ **N** ☐ If yes, please indicate from where: _____

Person Responsible for Account if Other than Patient

Name: _____ Relation to Patient: _____ Phone: _____

Date of Birth: _____ Social Security #: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Relation to patient: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance Company: _____ Policy Holder: _____

Relation to policy holder: _____ Policy Holder's Date of Birth: _____

Policy Holder's ID #: _____ Group #: _____ Social Security #: _____

Insurance Company Phone #: _____

PAYMENT IS DUE AT TIME OF SERVICE

I understand that I am responsible for payment of services rendered by Dental Smiles of Livonia, and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the Dental Smiles of Livonia to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Printed Name: _____ Date: _____

Signature: _____ Date: _____

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Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this information carefully.

We keep these records: We keep information about you that includes identifying information like your name, birth date, ID number and other personal information. We also keep a record of your goals, diagnosis and treatment we and others give you.

Our Privacy Commitment to You: We care about your privacy. The information we collect about you is private. We are required to give you this notice of our privacy practices. Only people who have the right and the need to see your information may do so. Unless you give us your permission in writing, we will only reveal your information for purposes of treatment, business operations or when we are required by law to do it.

- Treatment: We may disclose medical information about you to coordinate your care with others. For example, we may share medical information with an emergency room that needs to treat you.
- Payment: We may use and disclose information so the care you get can get properly billed and paid for. For example, we may give an insurance or community health agency details of the treatment we give you so they will pay for it.
- Business Operations: We may need to use and disclose information for our business operations. For example, we may use information to review the quality of care you get.
- Exceptions: For certain kinds of records, your permission may be needed even for operations. For example, psychotherapy notes are protected by the therapist.
- As Required by Law: We will release information when we are required to do so by law. For example, for law enforcement, national security, court order, communicable disease reporting, disaster relief, review of our activities by the government or to avoid a serious threat to health or safety of others.

Your Privacy Rights: You have the following rights regarding the health information we keep about you.

- Your right to inspect and copy. In most cases, you have the right to look at or get copies of your records. You may be charged a fee for the cost of coping records.
- Your Right to Amend: You may ask us to change your records if you feel there is a mistake. We can deny your request for certain reasons, but we must give you a written reason for our denial.
- Your Right to a List of Disclosures: You have the right to a list of disclosures made after this notice takes effect. This list will not include the times we disclosed information for treatment, payment or health care operations or information we gave you, your family or information that was shared with your permission.
- Your Right to Request Restrictions on Our Use or Disclosure of Information: You may ask for limits on how your information is used or disclosed. We are not required to agree to such requests.
- Your Right to Request Confidential Communications: You may request that we share information with you in certain ways or places, such as mailing information to a family member's address instead of your home. You do not have to give a reason for this request.

Changes to this Notice: We have the right to change this notice and we will always notify you if we revised this notice.

Copies of this Notice: You have the right to get a copy of this notice at any time just by asking for it. You may also request a longer, more detailed version of this Notice.

Complaints: If you believe your privacy rights as explained in this Notice have been violated, you have the right to complain. Complaints must be in writing. You can complain to any of the following:

Federal Government:
Office of Civil Rights
Dept. of Health and Human Services
233 N. Michigan Ave., Ste. 240
Chicago, IL 60601

You will not be penalized by us or the government for filing a complaint.

This document was reviewed and discussed on:

_____

Patient/Guardian Signature Date

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Medical History

Primary Care Doctor Name: _____ PCP phone number: _____ Last visit: _____

Pharmacy Name: _____ Pharmacy phone number: _____

Have you ever been told that you need antibiotics before dental treatment? Y ☐ N ☐ If yes, explain: _____

Are you taking any medications? Y ☐ N ☐ If yes, please list: _____

Do you now have, or have you ever had, any of the following?

1. Breathing problems
   - Asthma..... Y ☐ N ☐
   - Other: _____ ..... Y ☐ N ☐
2. Heart or blood vessel problems
   - High blood pressure..... Y ☐ N ☐
   - Stroke ..... Y ☐ N ☐
   - Heart attack ..... Y ☐ N ☐
   - Valve replacement/repair..... Y ☐ N ☐
   - Other: _____ ..... Y ☐ N ☐
3. Major surgery..... Y ☐ N ☐
4. Brain or nerve problem..... Y ☐ N ☐
5. Kidney or urinary problem ..... Y ☐ N ☐
6. Stomach problem ..... Y ☐ N ☐
7. Liver problem (including hepatitis) .....Y ☐ N ☐
8. Intestinal problem ..... Y ☐ N ☐
9. Skin problems ..... Y ☐ N ☐
10. Muscle/bone/joint problems ..... Y ☐ N ☐
11. Artificial joint replacement(s) ..... Y ☐ N ☐
12. Blood or immune problems..... Y ☐ N ☐
13. Thyroid or hormonal problems ..... Y ☐ N ☐
14. Cancer or therapy (radiation, chemotherapy).....Y ☐ N ☐
15. Anti-bone resorption agents (bisphosphonates or densumab)..... Y ☐ N ☐
16. Mental health conditions..... Y ☐ N ☐
17. Use of tobacco products..... Y ☐ N ☐
18. Alcohol use ..... Y ☐ N ☐
19. Recreational drug use..... Y ☐ N ☐
20. Have/had any infectious diseases (HIV, tuberculosis, hepatitis, venereal disease, etc)..... Y ☐ N ☐
21. Diabetes ..... Y ☐ N ☐
22. Epilepsy ..... Y ☐ N ☐
23. Arthritis ..... Y ☐ N ☐
24. Allergic reactions to
   - Penicillin ..... Y ☐ N ☐
   - Other antibiotics ..... Y ☐ N ☐
   - Local anesthetics ..... Y ☐ N ☐
   - Latex ..... Y ☐ N ☐
   - Other: _____ ..... Y ☐ N ☐
25. Other medical problems: ..... Y ☐ N ☐

   _____

   _____
26. Complete if female: ..... Y ☐ N/A ☐
   - Are you pregnant? ..... Y ☐ N ☐
     Week number: _____
   - Breast feeding?..... Y ☐ N ☐
   - Taking birth control pills? ..... Y ☐ N ☐

If yes to any of the above, please explain:

_____

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Dental Smiles of Livonia of any changes in my medical status. I authorize dental staff to perform the necessary dental services I may need, including x-rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my dental needs.

Name (please print): _____ Signature: _____ Date: _____

Doctor's signature: _____ Date: _____ Medical update: _____ Date: _____

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Dental History

What is the reason for your dental visit? _____

Are you having discomfort at this time? **Y** ☐ **N** ☐ If yes, explain: _____

Last Dental Visit Date: _____ Location: _____ Phone: _____

Did you have dental x-rays taken? **Y** ☐ **N** ☐ If yes, when: _____

What other dental treatment have you had done? _____

1. Are your teeth sensitive?.....Y ☐ N ☐
   - If yes, explain which teeth and when they are sensitive: _____
2. Do you brush your teeth? .....Y ☐ N ☐
   - If yes, how often: _____
3. Do you floss your teeth?..... Y ☐ N ☐
   - If yes, how often?: _____
4. Do you have any jaw joint problems? .....Y ☐ N ☐
   - If yes, please explain: _____
5. Have you ever had any injury to your face, teeth or jaw? ..... Y ☐ N ☐
   - If yes, please explain: _____
6. Do you grind or clench your teeth? .....Y ☐ N ☐
7. Do you have bleeding gums? .....Y ☐ N ☐
8. Do you have bad breath? ..... Y ☐ N ☐
9. Do you notice any swelling or lumps in your mouth? ..... Y ☐ N ☐

How do you feel about going to the dentist?: _____

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

Any other dental problems, concerns, or information: _____

_____

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Dental Smiles of Livonia of any changes in my medical status. I authorize dental staff to perform the necessary dental services I may need, including x-rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my dental needs.

Name (please print): _____ Signature: _____ Date: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.