PATIENT REGISTRATION

PERSONAL INFORMATION

Date: ____________________

Name: (First) ____________________ (Last) ____________________ SS #: ____________________

Address: ____

City: ____________________ State: ________ Zip: ____________

Telephone: (Home) ________________ (Work) ____________________

(Cell) ________________ (E-Mail) ____

Birthdate: ____________ Sex: ☐M ☐F ☐Other

Martial Status: ☐Single ☐Married ☐Child ☐Widowed ☐Divorced Spouse Name: ____________________

Occupation: ________________________________ How did you hear about us? ____________________

PERSON RESPONSIBLE FOR ACCOUNT

Name: ____________________ Relationship: ____________________ SS #: ____________________

Address: ____

City: ____________________ State: ________ Zip: ____________

Telephone: (Home) ________________ (Work) ____________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co: ____ Phone: ____________________

Insurance Co. Address: ____

Subscriber Name: ________________________________ Subscriber ID/SS #: ____________________

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

Employer: ____ Group #: ____________________

Secondary Insurance Co: ____ Phone: ____________________

Insurance Co. Address: ____

Subscriber Name: ________________________________ Subscriber ID/SS #: ____________________

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

Employer: ____ Group #: ____________________

I understand that payment is my obligation regardless of insurance or any other third party involvement.

____ ____________________

Patient/Guardian Signature Date

HEALTH HISTORY

Patient Name: (First) ________________ (Last) ________________ **Birthdate:** ________________

MEDICAL HISTORY

1. Physician's Name: ________________ Phone: ________________
   Have you had any medical care within the past two years? .... ☐ Yes ☐ No
   Describe: ________________
2. List any medication, drugs, pills or herbal remedies, including regular dosages of aspirin you are currently taking:

☐ MED 1	☐ MED 5
☐ MED 2	☐ MED 6
☐ MED 3	☐ MED 7
☐ MED 4	☐ MED 8

For patients updating in-office: Mark any medications that you are no longer taking and add any new ones.

3. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? .... ☐ Yes ☐ No
   If yes, please list name and dosage: ________________
4. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ..... ☐ Yes ☐ No
   If yes, please specify: ________________
5. Have you been a patient in the hospital during the past five years? .... ☐ Yes ☐ No
6. Indicate which of the following you have had, or have at present. Check "Yes" or "No"" to each item.

Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Artificial Heart Valve/Pacemaker	☐ Yes	☐ No	Hepatitis ☐ A ☐ B ☐ C	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	A.I.D.S./H.I.V. Positive	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Liver Disease/Yellow Jaundice	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Nervous/Anxious	☐ Yes	☐ No

Allergy/Hives ☐ Yes ☐ No
Allergy to Metals ☐ Yes ☐ No
Psychiatric/Psychological Care ☐ Yes ☐ No
Cancer ☐ Yes ☐ No

7. Do you have or have you had any disease, condition, or problem not listed? .... ☐ Yes ☐ No
   If yes, please list: ______________________________
8. Have you ever been prescribed a CPAP or diagnosed with Sleep Apnea? .... ☐ Yes ☐ No
9. **Women:** Are you pregnant or think you could be pregnant? ☐ Yes _______ Months ☐ No
   Nursing? ☐ Yes ☐ No

DENTAL HISTORY

Welcome! Please complete this dental history form so that we may provide you with the best possible dental care. All information is completely confidential.

What is the reason for your visit today?

____

Date of Last Dental Cleaning: ______________ Last Full Mouth X-rays: ______________

Previous Dentist's Name: ______________________________ State: __________

How often do you brush your teeth? ______________ How often do you floss? ______________

What other dental aids do you use (interplak, toothpick, etc.)? ______________________________

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: ______________________________

Are any of your teeth sensitive to:

Hot or cold? .... ☐ Yes ☐ No
Sweets? .... ☐ Yes ☐ No
Biting or chewing? .... ☐ Yes ☐ No
Have you ever noticed any mouth odors or bad tastes? .... ☐ Yes ☐ No
Do you frequently get cold sores, blisters or any other oral lesions? .... ☐ Yes ☐ No
Do your gums bleed or hurt? .... ☐ Yes ☐ No
Have you noticed any loose teeth or changes in your bite? .... ☐ Yes ☐ No
Does food tend to get caught in between your teeth? .... ☐ Yes ☐ No

Do you:

Clench or grind your teeth while awake or asleep? .... ☐ Yes ☐ No
Mouth breathe while awake or asleep? ☐ Yes ☐ No
Have tired jaws, especially in the morning? .... ☐ Yes ☐ No
Snore or have any other sleeping disorders? .... ☐ Yes ☐ No
Smoke/chew tobacco or use other tobacco products? .... ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment? .... ☐ Yes ☐ No
Oral Surgery? .... ☐ Yes ☐ No
Periodontal treatment? .... ☐ Yes ☐ No
Your teeth ground or the bite adjusted? ☐ Yes ☐ No
A bite plate or mouth guard? .... ☐ Yes ☐ No
A serious injury to the mouth or head? ☐ Yes ☐ No
If yes, please describe, including cause:

____
____
____

Have you experienced:

Clicking or popping of the jaw? .... ☐ Yes ☐ No
Pain? (joint, ear, side of face) .... ☐ Yes ☐ No
Difficulty in opening or closing the mouth? .... ☐ Yes ☐ No
Headaches, neck aches or shoulder aches? .... ☐ Yes ☐ No

Are you satisfied with your teeth's appearance? .... ☐ Yes ☐ No
Would you like to keep all of your teeth all of your life? .... ☐ Yes ☐ No

Do you feel nervous about having dental treatment? .... ☐ Yes ☐ No
If yes, please describe: ______________________________
Have you ever had an upsetting dental experience? .... ☐ Yes ☐ No
If yes, please describe: ______________________________
Have you ever been told to take a pre-medication prior to dental treatment? .... ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? .... ☐ Yes ☐ No

If yes, please describe: ______________________________

____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

______________________________ ______________

Patient/Guardian Signature Date

LAKETOWN FAMILY DENTAL AND YOUR INSURANCE PLAN
HOW THEY WORK TOGETHER

The staff at Laketown Family Dental is pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of those benefits. With this in mind, please read the information on our insurance claims process so that we can work together to ensure this be

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

I THOUGHT I PAID MY PORTION, BUT I GOT A BILL, WHY?

We base the patient portion of your bill on our most current data but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to joining the Laketown Family Dental family, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies DO NOT (and cannot in most cases) notify us of changes to your benefits, they only notify you. Your insurance company also has what they call reasonable and customary charges and these are what the percentage they pay is based on.

INSURANCE DIDN'T PAY, NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, Laketown Family Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract.
ULTIMATELY, YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED IN OUR OFFICE.

FINANCIAL OPTIONS

Laketown Family Dental does request payment in full for your portion at the time of service. We accept Mastercard, VISA, Discover, and HSA cards. If you are in need of extended finance options, we also work with Cherry Pay and Care Credit (who offer interest free options). Just ask us to send you a link.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Laketown Family Dental.

Patient Name: (First) ____________ (Last) ____________ **Birthdate:** ____________

______________________________ ______________

Patient/Guardian Signature Date

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us at 231-737-2273.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways:

TREAT YOU

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

BILL FOR YOUR SERVICES

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

We can use or share your information for health research.

COMPLY WITH THE LAW

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

FOR MORE INFORMATION SEE:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2003, the new 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 (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first 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.

From time to time, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PATIENT ACKNOWLEDGEMENT

Patient Name: (First) ______________________ (Last) ______________________ **Birthdate:** ________________

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.

____

Parent/Guardian Name *
*If parent or guardian is signing for a minor patient.

____

Patient/Guardian Signature

PATIENT DISCLOSURE PREFERENCES

Patient Name: (First) ______________________ (Last) ______________________ **Birthdate:** ______________

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone
- ☐ Cell Telephone
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

I allow you to give my clinical information to or answer questions from (check all that apply):

- ☐ Spouse Name: ______________________
- ☐ Parent Name: ______________________
- ☐ Child Name: ______________________
- ☐ Other (specify) Name: ______________________

____

Parent/Guardian Name *
*If parent or guardian is signing for a minor patient.

____

Patient/Guardian Signature

X-RAY RECORDS RELEASE REQUEST

Drs. Eric and Ariel Heisser, DDS
340 Seminole Road
Norton Shores, Michigan 49444
Office (231) 737-2273 FAX (231) 739-5309

Digital x-rays please EMAIL:

Scheduling@LaketownFamilyDental.com

FILM x-rays please send by mail

Patient Name: ___________________________________DOB: ________________________

Patient Name: ___________________________________DOB: ________________________

Dental office: _____________________________Ph#: ______________________

***I request and authorize the release of my records to Laketown Family Dental**

Patient Signature: ________________________________ Date: ________________________

**Bottom portion is to be filled out by dental office.*

Last Recall Appointment: _____________________________________

Most recent FMX Date: _____________________

Most recent PANO Date: _____________________

Most recent BWX's Date: _____________________