

Patient Information

Patient Name: _____
Last First MI
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
E-Mail Address: _____
Address: _____
Street Apartment #
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stroke (Year _____) |
| _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> NSAID Allergy | <input type="checkbox"/> Thyroid <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis Type _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints/Premed | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur/Premed | Due date: _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Radiation Treatment | _____ |
| <input type="checkbox"/> Cancer Type _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems | _____ |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic Fever/Premed | _____ |
| <input type="checkbox"/> Diabetes Type _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems | _____ |

• Name of Physician: _____ Phone: _____ Fax: _____

Referral Information

Whom may we thank for referring you to our practice?

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Another Patient | <input type="checkbox"/> Newspaper | <input type="checkbox"/> AT&T Yellow Pages |
| <input type="checkbox"/> Another Doctor | <input type="checkbox"/> Radio | <input type="checkbox"/> Hometown Yellow Pages |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Website | <input type="checkbox"/> Yellow Book |

Name of source referring you to our practice: _____

HIPAA

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, which contains information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement, 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 of 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.

Occasionally 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 testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Assignment of Insurance Benefits, Payment Policy, and Payment Options

The policy of MCDental Care, PLLC is to be paid directly by your insurance company. By signing the Consent for Services, you authorize direct payment to MCDental Care, PLLC and assume responsibility of all non-covered services or provider charges that may exceed insurance payment.

Our payment policies are as follows:

- **Payment is required the day services are rendered.**
- **If you are unprepared to pay your balance, a \$30 "Bill Me Later" fee will be charged to your account, in which case we must keep a valid credit card number on file, or a post-dated check. The balance must be paid within 2 weeks from the day you request to billed.**
- **Returned checks are subject to a \$30 NSF fee and may be subject to an additional collection fee.**
- **Balances over 30 days may be subject to additional collection action.**
- **All accounts not paid within 90 days will automatically be sent to a collection agency.**

For your convenience, we offer several payment options. Please read the following information:

- **Cash or Check.**
- **Visa, MasterCard, Discover, or American Express.**
- **Monthly payments include interest-free financing upon approval with CareCredit or ALLCare.**
- **Pre-payment entitles you to a 10% discount off your entire treatment plan. Your treatment plan must be pre-paid in one combined payment at least one week prior to your scheduled treatment.**

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services not paid by insurance are charged directly to the patient and that he or she is personally responsible. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1_% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless written financial arrangements are satisfied.

Patient Acknowledgement/Consent

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

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

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date: _____