DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______________________

SS/HIC/Patient ID # ______________________

Patient Name ______________________
Last Name

____
First Name Middle Initial

Address ______________________

E-mail ______________________

City ______________________

State ____________ Zip ____________

Sex ☐ M ☐ F Age ____________

Birthdate ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______________________

Occupation ______________________

Employer/School Address ______________________

____

Employer/School Phone (_____) ______________________

Spouse's Name ______________________

Birthdate ______________________

SS# ______________________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

2 DENTAL INSURANCE

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ____________ SS# ____________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr.______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient

3 PHONE NUMBERS

Home (______) ____________ Work (______) ____________ Ext ______ Cell Phone (______) ____________

Spouse's Work (______) ____________ Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______________________ Relationship ______________________

Home Phone (______) ______________________ Work Phone (______) ______________________

4 DENTAL HISTORY

Reason for today's visit ______________________

____

Former Dentist ______________________

City/State ______________________

Date of last dental visit ______________________

Date of last dental X-rays ______________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath ☐ Yes ☐ No
Bleeding gums ☐ Yes ☐ No
Blisters on lips or mouth ☐ Yes ☐ No
Burning sensation on tongue ☐ Yes ☐ No
Chew on one side of mouth ☐ Yes ☐ No
Cigarette, pipe, or cigar smoking ☐ Yes ☐ No
Clicking or popping jaw ☐ Yes ☐ No
Dry mouth ☐ Yes ☐ No
Fingernail biting ☐ Yes ☐ No
Food collection between the teeth ☐ Yes ☐ No
Foreign objects ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No
Gums swollen or tender ☐ Yes ☐ No
Jaw pain or tiredness ☐ Yes ☐ No
Lip or cheek biting ☐ Yes ☐ No
Loose teeth or broken fillings ☐ Yes ☐ No
Mouth breathing ☐ Yes ☐ No
Mouth pain, brushing ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No
Pain around ear ☐ Yes ☐ No
Periodontal treatment ☐ Yes ☐ No
Sensitivity to cold ☐ Yes ☐ No
Sensitivity to heat ☐ Yes ☐ No
Sensitivity to sweets ☐ Yes ☐ No
Sensitivity when biting ☐ Yes ☐ No
Sores or growths in your mouth ☐ Yes ☐ No

How often do you floss? ______________________

How often do you brush? ______________________

– O V E R –

5 HEALTH HISTORY

Physician's Name ______________________ Date of last visit__________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type ________	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date__________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name______________________

Phone (______) ______________________

ALLERGIES

☐ Aspirin
☐ Local Anesthetic
☐ Barbiturates (Sleeping pills)
☐ Penicillin
☐ Codeine
☐ Sulfa
☐ Iodine
☐ Other__________
☐ Latex
____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications?__________ If so, what?__________

Patient's Signature ______________________ Date__________

Doctor's Signature ______________________ Date__________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications?__________ If so, what?__________

Patient's Signature ______________________ Date__________

Doctor's Signature ______________________ Date__________

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.

From time to time it may be necessary for us to make disclosures of your information in connection with our 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

Please sign this form below to acknowledge that you have today either received or reviewed a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

________________________ ______________________________

Patient Signature Patient Name (please print)

I am also signing for my minor children: ____
(please print names)

Date: ________________

Patient Consent

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

______________________________________ ____

Patient Signature Patient Name (please print)

I am also signing for my minor children: ____

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, care giver)

____
(please print names)

____

____

I also give my permission for information regarding ____ appointments, ___ insurance benefits, ___ financial arrangements to be discussed with the above individuals, except: ____

Date: __________________

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

____

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

____________________________________ __________________________________

Office Personnel (signature) Office Personnel (print name)

Date: ______________________________

PATIENT COMMUNICATION PREFERENCES

To Our Valued Patients:

We are updating our records to determine the best way to communicate with you regarding treatment and appointments in our practice, as well as information regarding your dental health.

Please let us know your preferred method for receiving messages from us:

☐ Cell phone – number: ______________________________
☐ Home phone – number: ______________________________
☐ Work phone – number: ______________________________
☐ Email: ______________________________

In the event you cannot be reached by phone, is there someone we may leave a message with? (e.g. spouse, partner) Name: ______________________
Relationship: ______________ Phone number: ______________

May we send text messages to you regarding your appointments? ____ Yes ____ No
Please send text messages to (number) ______________________

May we send e-mail messages to you regarding your appointments? ____ Yes ____ No

In the future we may send electronic billing statements to you when applicable.
Would you like to receive electronic statements from our practice? ____ Yes ____ No

Would you like to receive electronic newsletters from our practice? ____ Yes ____ No

______________________ ______________________
Name Signature

____
Date

Informed Consent for General Dental Procedures

You, the patient have the right to accept or reject treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or option of no treatment.

Do not consent to treatment unless and until you potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, commonly known risks and potential complications are associated with dental treatment. No one can guarantee the success of recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

1. Pain, swelling, and discomfort after treatment
2. Infection in need of medication, follow-up procedures, or other treatment
3. Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, and/or tongue along with possible loss of taste
4. Damage to adjacent teeth, restorations, or gums
5. Possible deterioration of your condition which may result in tooth loss
6. The need fro replacement of restorations, implants, or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow up care and treatment, or consultation by a dental specialist
9. A root tip, bone fragment, or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop
10. Jaw fracture
11. If upper teeth are treated, a chance of a sinus infection or opening between the mouth and sinus cavity exists, which may need further treatment
12. Allergic reaction to anesthetic or medication
13. Need for follow up care and treatment including surgery

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase your chances for a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you have a heart condition or heart murmur, advise your dentist immediately so he/she can consult your physician.

The patient is an important member of the treatment team. In addition to complying with instructions given to you by this office, it is important to report any problems or complications you experience so your dentist can address them.

If you are a women on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking, antibiotics.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential risks and complications of recommended treatment with your dentist. Be certain your dentist addresses all of your concerns to your satisfaction before commencing treatment.

*Patient or Guardians Signature:*______________________________________ *Date:*______________

FINANCIAL OPTIONS

Payment for service is expected at the time service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. Cash, personal checks, and credit cards are accepted forms of payment. If an extended payment plan is desired, please ask about the CareCredit program. For charges of $500 or greater, a 5% courtesy discount will be extended for cash or check payment made in advance.

If you are working with a dental insurance, as a courtesy, we will file your dental claims for you. We may accept direct payment from most insurance companies. We will do our best to estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount owed to our office may be adjusted accordingly. You my find that our fees may be different from the insurance company's schedule of "allowable" or "URC" fees. If you have questions regarding URC fees, please feel free to ask. All services rendered are charge directly to the patient, and the patient is ultimately responsible for the amount regardless of the insurance coverage. Any denied insurance claims or claims remaining unpaid after 60 days will automatically become the responsibility of the patient.

- **CASH or CHECK**
  We accept cash or checks for all services. (A $50 fee will be charged for all bounced checks)
- **MASTERCARD, VISA, AMERICAN EXPRESS OR DISCOVER**
  We accept these major credit cards to allow you the most convenience in taking care of your account.
- **CARE CREDIT**
  For those patients that would like to pay a little each month. We've made special arrangements to be able to complete all your treatment while you make comfortable monthly payments. One of our team members will be happy to assist you and explain how the program works.

Please Designate A Financial Option

__ Cash or Check __ MC __ Visa __ AMEX __ Discover __ CARE CREDIT

______________________________ Card number   _______________ expiration date

I understand the above financial arrangements and agree that all services rendered to me, my dependants, or others assigned by me to my account are charged directly to me. I further understand that I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fee for the professional service not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 15% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added.

Signature: ______________________________ ***Date:*** ___________________________

MISSED APPOINTMENT & CANCELLATION POLICY

Our office reserves time aside especially for your appointment, any last minute cancellations inconveniences everyone. Therefore, we request that you kindly provide us with at least a **48** hour notice before canceling any future appointments. We often have a list of patients waiting to be scheduled and when you give us notice, we are able to accommodate others. Thank you for your understanding!

Please read the policy below and sign where indicated:

- If you need to reschedule or cancel an appointment, please give us **48 hour** notice to avoid a charge

- If you fail to arrive for your scheduled appointment and have not given us a **48 hour** notice, you will be charged a missed appointment fee.

- The charge for a missed or cancelled appointment not within **48 hours** of the scheduled appointment for professional hygiene visit is **$25**, and for a cancelled or missed appointment with any of our doctors would be **$50**. This is not covered by insurance plans and is your responsibility to pay.

Patient Signature:________________________________ Date:________

Dolores J. Baran, D.D.S., P.C.
Cosmetic & General Dentistry

1103 N. Main Street, Suite A _www.royaloaksmiles.com_ **_(248) 548-1440_**
Royal Oak, MI 48067 _Fax: (248) 548-3880_

RELEASE OF RECORDS

I, ______________________hereby authorize ________________________ to release my dental records. These records may include x-rays, treatment notes, charting, medical and dental history, photographs, or other notations relevant to my treatment.

These records may be released to:

1. My dentist / doctor ______1103 N MAIN ST SUITE A________________.
   Address: ______Royal Oak, MI. 48067________________.
   dbarandds@sbcglobal.net____________________________

2. Sent to my home address.

3. Released to a person authorized by me: ___________________________

4. Personally picked up my records today.

_____________________________________ ______________________
Signature Date

Denied Claim Patient Appeal Letter One

Date:______________________________

Insurance Company:__________________

Address:____________________________

City:________ State:____ Zip code:________

Patient/Policyholder Name: _____________

Policy Number:_______________________

Claim Number: _______________________

Date of Service:______________________

To Whom It May Concern:

I have received correspondence from your company that my claim for services was denied as not necessary. I am filing an appeal of these denied fees in expectation of eligibility and that your company will provide "good faith" administration of my benefits.

Dolores J. Baran D.D.S. provides me with a comprehensive level of care and coordination of treatment warranted by my dental needs. The submitted claim included x-rays and all necessary documentation. They clearly support the level of service provided.

What is your definition of "good faith"? Would you question your well-trained, licensed dentist who is personally involved with your care when evidence exists to support their treatment plan and my policy does not exclude such care?

To you, this may be just another claim. To me, it is my dental care needs and I pay for coverage for those needs. Good oral health is a vital element to overall health. Are you suggesting I cut corners in my dental care needs and in doing so jeopardize my health care? Is your company or reviewing professional willing to absorb any financial and legal liability for my future dental and health care needs that may be affected by your refusal of coverage? If additional information is required, please advise me promptly what specifically is required and for what purpose.

If you are prepared to deny these services, please provide me with dated and documented criteria and research that establishes your position. I am also requesting the name and credentials of the peer professional who reviewed my records and any conflict of interest in that professional who is making the determination of eligibility of services (such as, are they on your payroll?) and what they reviewed and in what format did they review it.
I am prepared to initiate a complaint process to the State or Federal agency that oversees my right to fair claims administration.

I await your reply.

Signature: ______________________________ Print: ______________________________