Family Dentistry of West Bloomfield
RONALD BERRIS DDS PC & JULIE K. GOLDSTEIN DDS
6400 Farmington Rd., West Bloomfield, MI 48322 248-661-4000 Fax 248-661-4003

Confidential Patient Registration & History

General Information

Title: Mr. ___ Mrs. ___ Ms. ___ Dr. ___ Other _____

Name: _____ **Birthdate:** _____/ _____/_____ **Sex:** ___M ___ F

Social Sec No: _____ **Student:** ____ **Marital Status:** Single ___ Married ___ Divorced ___ Widowed ___

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

Home #: _____ **Cell #:** _____ **Work #:** _____

Email: _____

If Student, name of school: _____ Are you eligible for dental insurance? _____

Referred by: _____

Emergency Contact: _____ **Phone #:** _____

Information of Person Responsible for Payment

Name: _____ **Self:** ____ **Spouse:** _____ **Dependent:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____ **Alt. Phone:** _____

Employer: _____ **Position:** _____

Business Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____ **ext** ____ **Alt. Phone:** _____

Social Sec No: _____ **Driver's License No.** _____

Credit Card No: _____ **Exp. Date:** _____

Dental Insurance Information

Primary Insurance Company: _____ Group Number: _____
Subscriber's Name: _____ Birthdate: _____
Social Sec. No: _____ or Alternate ID: _____
Employer: _____ Business Phone _____ ext _____
Business Address: _____
Patient's Relationship to Subscriber: Self _____ Spouse _____ Dependent _____
Does your insurance policy have Coordination of Benefits? Yes _____ No _____

Secondary Insurance Company: _____ Group Number: _____
Subscriber's Name: _____ Birthdate: _____
Social Sec. No: _____ or Alternate ID: _____
Employer: _____ Business Phone _____ ext _____
Business Address: _____
Patient's Relationship to Subscriber: Self _____ Spouse _____ Dependent _____
Does your insurance policy have Coordination of Benefits? Yes _____ No _____
Are you familiar with your insurance company's dental plan? Yes _____ No _____

TO ENSURE AND PROVIDE ACCURATE TREATMENT, ALL INFORMATION MUST BE COMPLETED!

CONFIDENTIAL PATIENT MEDICAL HISTORY

1. Are you in good health? …… Yes ____ No ____
2. Has there been any change in your general health within the last year? …… Yes ____ No ____
3. My last physical exam was on (approximate date) _____
4. Have you been a patient in the hospital during the past two years? …… Yes ____ No ____
5. Have you been under the care of a medical doctor during the past two years? …… Yes ____ No ____
   Physician's Name: _____ Phone Number: _____
6. Are you taking any medications now? …… Yes ____ No ____

CURRENT MEDICATION	REASON	CURRENT MEDICATION	REASON
_____		_____	
_____		_____	
_____		_____	
_____		_____	

7. Do you take aspirin daily? Yes ____ No ____ How much? _____
8. Are you allergic or have you reacted adversely to any of the following?

___ Aspirin	___ Penicillin	___ Other Antibiotics	___ Dental Anesthetic
___ Darvon	___ Erythromycin	___ Iodine	___ Latex/Vinyl
___ Codeine	___ Tetracycline	___ Nitrous Oxide	___ Foods
___ Motrin/Ibuprofen	___ Sulfa	___ Anesthetic	___ Other _____

9. Are you aware of being allergic to any other medications or substances? ……Yes ____ No _____
   If yes, please list: _____
10. Are you ever short of breath or exhibit chest pains upon mild exertion? …… Yes ____ No _____
11. Do you urinate more than six times per night? …… Yes ____ No _____
12. Are you on a special diet? …… Yes ____ No _____
13. Do you smoke? Yes ____ No _____ How many packs per day? _____ Number of years? _____
14. Do you drink alcohol? Yes ____ No _____ How much per week? _____
15. **Check any of the following which you have had or have at present:**

__Heart Disease / Attack	__ Emphysema	__ AIDS/HIV+
__ Angina Pectoris	__ Persistent Cough	__ Hepatitis A (Infectious)
__ Mitral Valve Prolapse	__ Tuberculosis (TB)	__ Hepatitis B (Serum)
__ High/Low Blood Pressure	__ Asthma	__ Hepatitis C/D
__ Prolonged Bleeding Time	__ Hay Fever	__ Liver Disease
__ Heart Murmur	__ Sinus Trouble	__ Alcoholism
__ Congenital Heart Lesions	__ Allergies or Hives	__ Drug Addiction
__ Scarlet/Rheumatic Fever	__ Diabetes	__ Hemophilia / Blood Disorders
__ Artificial Heart Valve	__ Thyroid Disorder	__ Sexually Transmitted Disease
__ Heart Pacemaker	__ Radiation Treatment	__ Cold Sores/Fever Blisters
__ Heart Surgery	__ Chemotherapy	__ Blood Transfusion
__ Stents	__ Cancer	__ Arthritis
__ Anemia	__ Epilepsy/Seizures	__Rheumatism
__ Fainting/Dizzy Spells	__ Stroke	__ Prolonged Use of Steroids
__ Nervousness	__ Kidney/Bladder Trouble	__ Glaucoma
__ Psychiatric Treatment	__ Ulcers	__ Pain in Jaw Joints
__ Sickle Cell Disease	__ Artificial Joints	__ Blood Disorders
__ Bruise Easily		

16. Do you have any disease, condition, or problem not listed? Yes ___ No ____ If so, what? _____

FOR WOMEN ONLY:

Are you pregnant? Yes ____ No ____ If yes, what month are you in? _____
Are you breastfeeding? Yes ____ No ____
Are you taking birth control pills? Yes ___ No ____

CONFIDENTIAL PATIENT MEDICAL HISTORY

1. What is your initial concern/chief dental complaint? _____
2. Are you experiencing any pain or discomfort at this time? Yes ____ No ____ What? _____
3. How long ago was your last dental appointment? _____
4. Previous Dentist _____ Phone: _____
5. When was the last time you had a complete set of x-rays? _____
6. Duration between teeth cleanings? 3 mos ____ 4 mos ____ 6 mos _____ Last cleaning date: _____
7. How often do you brush your teeth? _____ times per day. Floss your teeth? Yes ____ No _____
8. Does food catch between your teeth? Yes ____ No ____ If so, where? _____
9. Do your gums ever bleed? Yes ____ No ____ If so, where? _____
10. Have you noticed any bad odors or tastes from your mouth? Yes ____ No ____
11. Are you aware that loss of bone supporting your teeth may occur without any symptoms? Yes ____ No ____
12. Have you noticed any loose teeth? ..... Yes ____ No ____
13. Are your teeth sensitive to hot, cold, chewing, or sweets? ..... Yes ____ No ____
14. Do you have pain in the area in front of your ear? .....Yes ____ No ____
15. Do you clench or grind your teeth in the daytime or at night?.....Yes ____ No ____
16. Does your jaw pop or click when you open or chew? ..... Yes ____ No ____

17. Check any of the following which you have had or have at the present:

__ Periodontal Treatment	__ TMJ/MPD Diagnosis	__ Missing Teeth	__ Bleaching
__ Orthodontic Treatment	__ Pain in Jaw	__ Occlusal Guard	__ Laminates/Bonding
__ Oral Surgery	__ Frequent Headaches	__ Bite Adjusted	__ Cold Sores/ Blisters
__ Implants	__ Ringing in Ears	__ Bridges	__ Dental Phobia
__ Root Canals	__ Trauma to Head	__ Crowns	__ Partial/Complete Dentures

18. Do you have any problems or dislikes associated with your previous dental treatment? _____
19. How do you react to Dental care? Dread it ___ Worry about it ___ Don't mind it ___ Love it! ___
20. Has financial obligation in the past limited your acceptance of ideal dental treatment? Yes ___ No ___
21. My mouth is: Comfortable ____ Moderately Comfortable ___ Uncomfortable ___
22. Are you satisfied with the appearance of your teeth? Yes ____ No ____
23. Would you like to improve the appearance of your teeth? Yes ____ No ____
    If yes, please indicate what you would like to change:
    Size: ____ Shape: ____ Spacing: ____ Alignment: ____ Color: ____

Parents:

If there is a need, may we:

Use a local anesthetic on your child? Yes ___ No ___ Administer nitrous oxide to your child? Yes ___ No ___
Apply Fluoride at each checkup? Yes ___ No ___ Take X-rays as needed? Yes ___ No ___

Child's Nickname: _____ Hobbies? _____

Parent/Guardian Signature: _____ Date: _____

WE REQUEST THAT YOU REMAIN IN OUR OFFICE WHILE YOUR CHILD IS BEING TREATED!

RESPONSIBILITY and CONSENT STATEMENT

I hereby authorize and request the performance of dental services for myself or the person designated on this form. I also give consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by attending dentist or by his supervised staff for diagnostic or dental treatment. Records take may include study models, photographs and blood studies. Additionally, the dentist needs a current full set of x-rays to accurately detect tooth decay and gum disease. I understand and acknowledge that I am financially responsible for the services provided for myself or the person designated by this form, regardless of insurance coverage. I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be notified of the need and its fee. Scheduling time is at a premium for all parties. **Therefore, as a courtesy , 24 hours prior notice is necessary to avoid a possible broken appointment charge.**

Signature of Patient _____ Date _____
Signature of Dentist _____ Date _____

For Staff Use

Updates To Medical History

Date

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

NOTES

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COMPLIANCE FORM

Our office calls to confirm appointments. This courtesy is labor intensive, time-consuming, and often requires several calls in an effort to reach the patient in person. The majority of patients remember schedule appointments and appreciate time reserved for their dental care. We appreciate your commitment and respect in honoring scheduling obligations. When a patient breaks or re-schedules their appointment without sufficient notice, the doctor or hygienist treatment time is unproductive. **Office policy is to charge a fee for broken appointments. In some instances, a fee has been charged for re-scheduled or cancelled appointments without 24 hours' notice.** This policy, because of our close relationship, has been difficult to implement and enforce. To reduce overhead costs and labor constraints, a change in appointment confirming is necessary. Improved efficiency requires shifting more responsibility to the patient.

For our new confirmation policy, we request that you indicate the cell and/or email procedure necessary to confirm your appointments.

Cell phone confirmation: **YES** **NO**
Cell phone number for Texting: _____

Email confirmation: **YES** **NO**
Email address: _____

When our office abides by your request and you do not honor your agreement, **please respect our policy and need to charge a fee.** Our relationship is mutually important to provide sufficient time and effective business practices.

Please sign and date below. This form will become a part of your permanent record.

X _____

Patient Signature Date

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PATIENT CONSENT/ACKNOWLEDGEMENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that our office comply with certain rules regarding the maintenance of your information that we have collected and will collect in the future. By signing below, you consent to the use and disclosure of your protected health information by RONALD BERRIS D.D.S., P.C., our staff, and our business associates for treatment, payment and health care operations.

For a more detailed description of uses and disclosures for these purposes, please request and review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If they do, you may request a revised Notice by contacting this office (248) 661-4000. We will also post any revised notice in the office.

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 or make disclosures of your information in connection with providing or coordinating your treatment. You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make fore treatment, payment and health care operations. If we agree to further restrictions, they are binding on us. However, we are not required to agree to these restrictions. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

I, _____, am aware of and understand this office's Notice of Privacy Practices. I understand that I may request a copy of this Notice.

Please Print Name _____ **Signature** **X**_____ **Date** _____

The above consent will apply to my children of record until they attain the age of 18.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign ___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement ___ Other (please specify

_____