PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

Phone _____ ❑Cell ❑Home ❑Work If minor, parents names _____

Mailing address _____ City _____State _____ Zip _____

Email address_____ ❑Married ❑Single ❑Divorced ❑Widowed

Social Security number: _____ Employer _____

Whom may we thank for referring you to our office? _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Dental Insurance Co._____ Member Id# _____ Ins Phone#_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's name _____ Spouse's employer _____ Birth date_____

Spouse's dental insurance Co. _____ Member Id# _____

Spouse's Social Security number _____ Ins Phone#_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

Signature of patient (or parent) _____ Date

_____

Roc Dental

HIPAA Privacy Act

I consent to receive dental treatment and hereby authorize payment directly to Roc Dental of any dental services performed from the insurance company I provide. I shall be legally responsible for any out of pocket costs, such as co-pays, deductibles and services that may not be covered under my policy. I authorize Roc Dental to release any medical information requested in the course of my treatment to my dental insurance company.

I hereby acknowledge review of the privacy statement offered.

Please check YES or NO for each:

Ok to leave messages on home, work or cell answering machine regarding medical conditions, prescription refills or billing and scheduling concerns.

- YES
- NO

Ok to leave a message with a spouse, guardian or family member regarding any medical conditions, prescription refills or billing and scheduling concerns.

- YES
- NO

* I attest that the above information is correct

Patient Name _____

Signature of Patient or Guardian _____Date _____

Roc Dental

Office Policy and Financial Arrangements

We are committed to providing you with the best possible care. If you have dental insurance, we are happy to assist you by contacting your insurance company for eligibility and billing however, we urge you to please check with your insurance company prior to any office procedures. We charge reasonable and customary rates for the state of Michigan. You are responsible for payment regardless of any insurance company's determination of usual and customary rates. Also, understand that not all services are a covered benefit in all contracts. While filing insurance claims is a courtesy we extend to all of our patients, all charges are your responsibility from the date the services are rendered. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your visit. Please remember that your insurance policy is between you and your insurance company and not between your insurance company and our office.

Payments for services are due at the time services are rendered unless our staff has approved payment arrangements. We will gladly discuss your treatment plan and answer any questions relating to your account and/ or your insurance coverage. Please, do not hesitate to ask us.

Your appointment time is valuable and has been reserved specifically for you. If it is necessary for you to reschedule your appointment please provide us with a 24 hour notice.

All appointments that are cancelled or rescheduled with less than 24-hour notice will have a $50.00 charge added to the account.

Thank you for your time and understanding in this matter.

☐ ***I understand and agree that I am responsible for giving a 24 hour notice if canceling or rescheduling any appointments; otherwise my account will be charged a $50.00 cancellation fee.***

☐ ***I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any services rendered. Your signature below verifies that you have read and understand this statement.***

Print Name: _____

Signature _____ **Date** _____