Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out the form completely in ink. If you have any questions or need assistance, please ask - we will be happy to help!

Patient Information (CONFIDENTIAL)

Date_____

Patient Name_____ Phone_____ Cell_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ SS/SIN#_____

Email_____

Check Appropriate Box: ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College_____ City_____ State_____ Zip_____

Spouse or Parent/Guardian's Name_____ Contact Phone_____

Person to contact in case of emergency_____ Phone_____

Whom may we thank for referring you?_____ Relationship to Patient_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

City, State, Zip_____ Cell Phone_____

SS#/SIN_____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SS#/SIN_____

Name of Employer_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Policy/ID#_____

IF YOU HAVE AN ADDITIONAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SS#/SIN_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Policy/ID#_____

Ins. Co. Address_____ City_____ State_____ Zip_____

For your convenience, we offer the following methods of payment. **Payment in full is due at each appointment.**

☐ Cash ☐ Personal Check Credit Cards: ☐ Visa ☐ MasterCard ☐ Discover ☐ Care Credit ☐ I wish to discuss the payment policy.

Over Please

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you currently taking any medication(s) including non-prescription medicine? If yes, please list - _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Do you wear contact lenses?	☐	☐
11. Are you allergic or have you had any reactions to:		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐
12. Do you have a persistent cough or throat clearing not linked to a known illness (lasting more than 3 weeks)?	☐	☐
13. **Women only**: Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting / Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy / Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐

	Yes	No
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis / Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐

	Yes	No
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever / Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Other _____	☐	

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?	☐	☐
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty opening or closing mouth	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement: _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Name of previous dentist_____ Phone_____

Address_____ City, State, Zip_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of Patient (or parent/guardian of minor) Date

Doctor's Signature_____

Date

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

The Art of Dentistry

Dr. Ronald A. Williams & Thomas J. Rydzon

2046 South State Rd. Suite A | Davison MI, 48423 | (810) 653-3503

Written Financial Policy

Thank you for choosing The Art of Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Our office requires payment prior to the completion of your treatment. If you need to make financial arrangements, the following are available to you. Please let us know prior to your appointment if that is necessary.

IF necessary, Payment Options Available:

You can choose:

- A 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care.

- MasterCard, Visa, American Express, Discover Card, Cash or Check
- No or low INTEREST Payment Plans offered in-house, or from Care Credit
    - Allow you to pay over time with NO or low INTEREST
    - Convenient, low monthly payment plans also available
    - No annual fees or pre-payment penalties

Please note for Payment Plans:

The estimated patient portion will be split into 3 monthly installments. Alternative payment arrangements may be provided. Ask at the desk for more information.

For patients with dental reimbursement policies, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

Our office charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

The Art of Dentistry

Practice Policies

Thank you for choosing our office to meet your dental health needs. It is our optimal goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. In order to keep our standard of care to a level which best serves your dental needs, we ask you to please observe the following policies.

Payment Options

We require payment in full at the services rendered, at the time of service.

As a courtesy, we will file your dental insurance claim for you. It becomes the patient's responsibility to cover the cost of procedures that are not covered by his or her dental reimbursement plan. Please note, not all services may be covered by your dental reimbursement plan, and every insurance plan has its own unique "quirks" and policy exceptions.

We accept the following methods of payment for services rendered:

- ☐ Cash
- ☐ Check
- ☐ Credit/ Debit Card
- ☐ Money order

Extended Payment Options available:

- ☐ Care Credit
- ☐ Postdated checks
- ☐ In office payment options

Cancellation Policy

Our office requires a minimum of 24 hours notice if an appointment must be cancelled. If less than 24 hours notice has been given to cancel an appointment, a $50 fee will be assessed. In the event that no notice is given and the patient does not show up for their scheduled appointment, a $75 fee will be assessed. *Please note that this fee is not covered by dental reimbursement plans and payment is the patient's responsibility.*

That being said, we do understand that emergencies happen. We only request that you look at our time as being as valuable as your time.

We at The Art of Dentistry, especially Dr. Williams and Dr. Rydzon, welcome you to our "family" and look forward to taking care of your oral health needs.

Please sign below acknowledging that you have read the practice policies.

Authorizing Signature:_____ Date:_____

Print Name:_____

CONSENT FOR TREATMENT

I hereby authorize Dr. Williams, Dr. Rydzon, or a designated staff member to take radiographs, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (patient name) _____'s dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

If I, the parent/guardian/legal power of attorney am unable to attend the appointment with the above named patient, I give authorization for treatment to be completed without my physical attendance.

_____

Patient Signature

_____

Parent/Legal Guardian/Power of Attorney Signature

_____

Relationship to Patient

_____

Date