

# Clio Family Dentistry

cliofamilydentistry@yahoo.com

www.cliofamilydentistry.com

4279 W. Vienna • Clio, MI 48420

(810)687-2000

## Welcome to our Practice

**Chart#:** \_\_\_\_\_

FOR OFFICE USE ONLY

**Patient Name:** \_\_\_\_\_  
Last First MI Preferred Name

**Title:** \_\_\_\_\_ **Gender:**  Male  Female **Family Status:**  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

**Birth Date:** \_\_\_\_\_ **SS#:** \_\_\_\_-\_\_\_\_-\_\_\_\_ **Prev. Visit:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Best time to call:** \_\_\_\_\_

**Phone:** \_\_\_\_\_  
Home Mobile Work Ext Fax Other

**Address:** \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

**How did you hear about our practice, or whom may we thank for referring you?**

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Friend  Location  Google  Facebook  Online-Other  Insurance

**Responsible Party Information:**

**This only needs to be filled out if the insurance subscriber is other than patient, or if patient is under 18.**

**The following is for:**  the patient's spouse  the person responsible for payment  both  neither-not applicable

**Name:** \_\_\_\_\_  
Last First MI Preferred Name

**Title:** \_\_\_\_\_ **Gender:**  Male  Female **Family Status:**  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

**Birth Date:** \_\_\_\_\_ **SS#:** \_\_\_\_-\_\_\_\_-\_\_\_\_ **DL#:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Best time to call:** \_\_\_\_\_

**Phone:** \_\_\_\_\_  
Home Mobile Work Ext Fax Other

**Address:** \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

**Primary Dental Insurance:**

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

**Insurance Authorization:**

\* By initialing this box,  
I authorize my insurance company to pay the dentist all insurance benefits rendered.  
I authorize the use of this electronic signature on all insurance submissions.  
I authorize the dentist to release all information necessary to secure the payment of benefits.  
I understand that I am financially responsible for all charges whether or not paid by insurance.

## Secondary Dental Insurance

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

## Medical History

Indicate which of the following conditions you HAVE or HAVE HAD. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> *Pre-Med - Amox      | <input type="checkbox"/> *Pre-Med - Clind     | <input type="checkbox"/> *Pre-Med - Other     | <input type="checkbox"/> *Pre-Med Keflex    |
| <input type="checkbox"/> Acid Reflux / GERD   | <input type="checkbox"/> Afib                 | <input type="checkbox"/> Allergies            | <input type="checkbox"/> Allergy - Aspirin  |
| <input type="checkbox"/> Allergy - Codeine    | <input type="checkbox"/> Allergy - Erythro    | <input type="checkbox"/> Allergy - Hay Fever  | <input type="checkbox"/> Allergy - Latex    |
| <input type="checkbox"/> Allergy - Other      | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa      | <input type="checkbox"/> Allergy- Bactrim   |
| <input type="checkbox"/> Allergy Keflex       | <input type="checkbox"/> Allergy Zithromax    | <input type="checkbox"/> Allergy-amoxicillin  | <input type="checkbox"/> Anemia             |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Artificial Valves    | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Blood Disease        | <input type="checkbox"/> Blood Thinners       | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Caution with EPI   |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Epilepsy / Seizures  | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Head Injuries        | <input type="checkbox"/> Heart Disease      |
| <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Hepatitis A          | <input type="checkbox"/> Hepatitis B        |
| <input type="checkbox"/> Hepatitis C          | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> HIV / AIDS positive  | <input type="checkbox"/> Jaundice           |
| <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> MRSA               |
| <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> No local anesthetic  | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Pregnant Currently |
| <input type="checkbox"/> Problems Sleeping    | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> Sleep Apnea          | <input type="checkbox"/> Smoker             |
| <input type="checkbox"/> Stomach Problems     | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Tetracycline Allergy | <input type="checkbox"/> TMJ Disorder       |
| <input type="checkbox"/> Trigeminal Neuralgia | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Tumors               | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Venereal Disease     |   |   |   |

If any conditions or alerts selected above need further clarification, please describe below:

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Do you take antibiotic premedication for your dental visits? If yes, please explain.  Yes  No

Are you currently taking or do you have a history of taking Biophosphate or anti-resorptive medications?

Yes  No

Have you ever taken any bone strengthening medications or injections?  Yes  No

Are you receiving or do you have a history of receiving radiation to the head, neck or jaw?  Yes  No

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin. If you have a list we can copy please write "see list" and give to our front desk team to copy it for you.

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Please list any recent surgeries and/or hospitalizations:

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Please provide your Physician's Name and Phone Number

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When was your last dental visit?

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What was your last dental procedure?

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Have you ever had Orthodontics?  Yes  No

Are you interested in replacing any missing teeth?  Yes  No

\* By initialing this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire. There are no other medical conditions or medications/allergies that have not been listed. I will notify of any changes.

## Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

\* **By initialiing this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

## Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

## Cancellation Policy

We appreciate and respect the time of our patients. Therefore, this practice does ask for a minimum of 24 hour notice for any cancellations or changes to our schedule. We reserve the right to charge \$50.00 per appointment if this policy is not adhered to. We specially reserve time for each patient. We do however, know that illness and emergencies occur and we do accomodate those rare instances. Thank you for choosing Clio Family Dentistry.

\* **By initialing this box, I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**



## HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

\* **By initialing this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

I acknowledge that I understand all questions and contents in the previous forms. I have completed all questions to my best ability and will comply with the office policies stated.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature

Signature \_\_\_\_\_ Date \_\_\_\_\_

Response Date:

\_\_\_\_/\_\_\_\_/\_\_\_\_