Patrick M. Michel, DMD, PA

PATIENT REGISTRATION

Date:_____

Patient Name: _____ Preferred Name: _____
FIRST MI LAST

Patient Address: _____ Birth Date:_____

City, State, Zip: _____

Soc Sec #: _____ Driver's License: _____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Email Address: _____ ○ I would like to receive correspondence via email.

Place of Employment:_____

Address of Employer:_____
STREET CITY STATE ZIP

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time ○ Not a Student

Preferred Appointment Times: ○ Morning ○ Afternoon ○ Any time

○ Monday ○ Tuesday ○ Wednesday ○ Thursday

How did you hear about us?_____

Responsible Party (if someone other than patient):

Name (First, MI, Last): _____Birth Date: _____

Address: _____ Social Security Number: _____

City, State, Zip:_____ Driver's License: _____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Primary Insurance Information:

Name of Insured: _____SS#_____ Birth Date: _____

Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Employer: _____ Ins Company: _____

Emp Address: _____ Ins Address: _____

Emp City, State, Zip: _____ Ins City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____SS#_____ Birth Date: _____

Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Employer: _____ Ins Company: _____

Emp Address: _____ Ins Address: _____

Emp City, State, Zip: _____ Ins City, State, Zip: _____

Patrick M. Michel, DMD, PA

Medical History

Patient:_____
Date:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

For new patients: Date of last dental visit:_____ Date of last dental x-rays:_____
Reason for this visit:_____

Are you under a physician's care now? ○Yes ○No If yes, please explain:_____

Have you ever been hospitalized or had a major operation? ○Yes ○No If yes, please explain:_____

Have you ever had a serious head or neck injury? ○Yes ○No If yes, please explain:_____

Do you use controlled substances? ○Yes ○No If yes, what kind?:_____

Have you ever had complications following dental treatment? ○Yes ○No If yes, please explain:_____

Women, are you…

Pregnant or trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○Yes ○No

Do you use tobacco? ○Yes ○No If yes, what kind?:_____

Are you taking any medications, pills, or drugs? ○Yes ○No If yes, please explain:_____

Are you taking any meds to improve your bone density? ○Yes ○No If yes, what kind?:_____

Are you allergic to any of the following? ○ No allergies

○Aspirin ○Penicillin ○Codeine ○Acrylic ○Metal ○Latex ○Local anesthetics ○Other:_____

Please mark all of the following you currently have or have had in the past.

○ AIDS	○ Cortisone Medicine	○ High Blood Pressure	○ Shingles
○ Alzheimer's	○ Diabetes type:_____	○ Hives or Rash	○ Sickle Cell Disease
○ Anaphylaxis	○ Drug Addiction	○ Hypoglycemia	○ Sinus Trouble
○ Anemia	○ Easily Winded	○ Irregular Heartbeat	○ Spina Bifida
○ Angina	○ Emphysema	○ Kidney Problems	○ Stomach/ Intestinal Disease
○ Arthritis/Gout	○ Epilepsy or Seizures	○ Leukemia	○ Stroke
○ Artificial Heart Valve	○ Excessive Bleeding	○ Liver Disease	○ Thyroid Disease
○ Artificial Joint	○ Excessive Thirst	○ Low Blood Pressure	○ Tonsilitis
○ Asthma	○ Fainting spells/ Dizziness	○ Lung Disease	○ Tuberculosis
○ Blood Disease	○ Frequent Headaches	○ Mitral Valve Prolapse	○ Tumors or Growths
○ Blood Transfusion	○ Genital Herpes	○ Pain in Jaw Joints	○ Ulcers
○ Breathing Problem	○ Hay Fever	○ Parathyoid Disease	○ Venereal Disease
○ Bruise Easily	○ Heart Attack/ Failure	○ Psychiatric Care	○ Yellow Jaundice
○ Cancer	○ Heart Murmur	○ Radiation Treatments	○ OTHER:
○ Chemotherapy	○ Heart Pace Maker	○ Recent Weight Loss	
○ Chest Pains	○ Heart Trouble/ Disease	○ Renal Dialysis	○ I do not currently have and have not previously had any of the above conditions or any other serious condition not listed above.
○ Cold Sores/ Fever Blisters	○ Hemophilia	○ Rheumatic Fever	
○ Congenital Heart Disorder	○ Hepatitis type:_____	○ Rheumatism	
○ Convulsions	○ Herpes	○ Scarlet Fever	

Emergency Contact: Name:_____Phone:_____
Comments:_____
_____
_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

Patrick M. Michel, DMD, PA

PERSONAL DENTAL PROFILE

Patient:_____
Date:_____

What dental problems have you had in the past?_____
_____
_____

What has been your experience with dentistry in the past?_____
_____
_____

Why did you change from your last dental office?_____
_____
_____

Have you ever been treated for gum disease?	○ Yes	○ No
Do your gums bleed?	○ Yes	○ No
Do you feel you have bad breath?	○ Yes	○ No
Do you wish your teeth were whiter?	○ Yes	○ No
Are you dissatisfied with the way your teeth are shaped?	○ Yes	○ No
Are you dissatisfied with your smile?	○ Yes	○ No
Have you been told that you snore?	○ Yes	○ No
Have you been told you grind your teeth?	○ Yes	○ No
Do you play sports?	○ Yes	○ No

If yes, which sports do you play?_____

How often do you brush your teeth?_____

How often do you floss your teeth?_____

On a scale from 1 to 10, how would you rate your apprehension with dental visits with 10 being very nervous?_____

On a scale from 1 to 10, how important is it for you to keep your teeth for a lifetime with 10 being very important?_____

What expectations do you have for your oral health in the future and how will you achieve these goals?_____
_____
_____
_____
_____
_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

MICHEL FAMILY DENTISTRY

Patrick M. Michel, DMD, PA

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **MICHEL FAMILY DENTISTRY** "NOTICE OF PRIVACY PRACTICES", revision date March 23, 2013.

As required by the Privacy Regulations, _____ from **MICHEL FAMILY DENTISTRY** has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **MICHEL FAMILY DENTISTRY** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- ❑ I wish to file a "Request for Restriction" of my Protected Health Information.
- ❑ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

_____

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".

I have read "NOTICE OF PRIVACY PRACTICES" and understand my rights contained in the notice. By way of my signature, I provide MICHEL FAMILY DENTISTRY with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (Printed)

_____ _____
Patient's Signature *Date*

_____ _____
Authorized Facility Signature or Parent/Guardian if Minor *Date*

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

The following effort was made to obtain receipt: (Describe)

_____

_____

Patrick M. Michel, DMD, PA

PATIENT'S AUTHORIZATION REQUEST FORM

You may give Dr. Patrick Michel written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below:

PLEASE PRINT:

Patient's Name:_____Middle Initial:____Last Name:_____

Patient's Date of Birth:_____/_____/_____

Patient's Address:_____

City:_____State:_____Zip:_____

Phone Number:_____

At my request, I authorize Patrick M. Michel, DMD, PA to disclose my Protected Health Information to:

Name:_____Relationship to Patient:_____

Name:_____Relationship to Patient:_____

Name:_____Relationship to Patient:_____

I, _____, authorize Patrick M. Michel, DMD, PA to disclose the following PHI to the person/ entity listed above. Check all that apply:

___Patient Information
___Payment Information
___Claims Information
___All services from a specific health care provider
___Benefit Information
___Explanation of Insurance Benefits
___All Information Requested

Patient's
Signature:_____Date:_____

(If the patient is a minor, the guardian needs to sign.)

Patrick M. Michel, DMD, PA
3314 Healy Drive, Suite 101
Winston-Salem, NC 27103

FINANCIAL POLICY

Thank you for selecting our office as your dental provider. The following is a statement of our financial policy which we ask that you **read, understand and sign prior to any treatment**. We are committed to the best possible dental care and we are happy to discuss our professional fees with you at any time during our normal office hours. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our providing you with financial policy, or your responsibility. Payment is requested at each appointment as service is rendered and can be made by **Cash, Check, Master Card, Visa, American Express, Discover, or Care Credit.** Please be aware that if you are a parent bringing a child to our office you are legally responsible for payments on all charges. We cannot send statements to other addresses.

DENTAL INSURANCE INFORMATION

As a courtesy to you, our patients, we will file your dental insurance claim for you. We also, as a courtesy to you, will accept assignment of benefits. We will only accept this assignment of benefits after you are a patient of record with us. Once we have verified your insurance benefits, we will begin filing your claims for you. For appointments such as cleanings, we will bill the insurance company. If you need to return for restorative, we will collect your yearly deductible at the time the service is rendered. If you are in need of a crown, bridge, or denture, we ask that you pay a portion of what you will be responsible for at the initial appointment, and that the remaining portion be paid at the delivery appointment. Please keep in mind we estimate what we think the insurance will pay. Once the insurance company reimburses us, you will be billed for any remaining balance.

You, the patient, are responsible for your entire account balance. If, for some reason, your insurance company becomes unduly difficult to deal with, we ask that you proceed with whatever measures you deem appropriate to collect on your claim. Please provide us with the following information in order to file your claim:

Patient's Name:_____
Employee Name:_____
Employee Date of Birth:_____
Employee Social Security Number:_____
Company Where Employed:_____
Insurance Company Name & Number:_____

I authorize the release of any information concerning mine or my child's dental care, advice, and treatment provided for the purposes of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me and I understand that I am financially responsible for payments in full of all accounts.

Signature of patient, parent, or guardian_____Date:_____