Patient Information Form

Personal Information:

Last Name:	First Name:	Middle Initial:
DOB:	Age:	Social Security Number:
Address:		
City:	State:	Zip Code:
Wireless Phone:	Home Phone:	E-mail:

Primary Insurance Information:	Secondary Insurance Information:
Insurance Carrier:	Insurance Carrier:
Insurance Carrier Phone:	Insurance Carrier Phone:
Employer:	Employer:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Member ID:	Member ID:
DOB:	DOB:
Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child	Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Emergency Contact Information:

Name of Contact:
Phone Number:
Relationship to Patient:
May we communicate information with this individual concerning your care? ☐ Yes ☐ No

Physician and Pharmacy Information:

Physician Name:	Phone Number:
Street Address:	City/State/Zip Code:
Date of Last Visit:	
Reason for Last Visit?	
Pharmacy Name:	Phone Number:
Street Address:	City/State/Zip Code:

Dental Information:

Prior Dentist Name:	
Date of Last Visit?	Date of Last X-rays?
Reason for Today's Visit:	

Authorization:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any of my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I am agreeing to responsibility of services not paid in full or part by my dental care payer.

I attest to the accuracy of the information on this page.

Patient or Guardian Signature Date

Last Name: _____ First Name: _____ DOB: _____

Health History Form

Dental and Medical Health History:

Please indicate if you currently have or have had any of the following. Checking the box indicates **"Yes"**, leaving blank indicates **"No"**.

Dental Conditions

- ☐ Bad Breath
- ☐ Blisters on Lips or Mouth
- ☐ Burning Sensation on Tongue
- ☐ Chew on One Side of Mouth
- ☐ Clench or Grind Teeth
- ☐ Dry Mouth
- ☐ Food Collection Between Teeth
- ☐ Growths or Sore Spots in Your Mouth
- ☐ Gums Swollen, Tender or Bleeding
- ☐ Head/Neck/Jaw Pain or Aches
- ☐ Lip or Cheek Biting
- ☐ Loose Teeth or Broken Fillings
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Nitrous Oxide
- ☐ Periodontal Treatment
- ☐ Sensitivity to Pressure/Cold/Heat/Sweets
- ☐ Smokeless Tobacco
- ☐ Cigarette, Pipe, or Cigar Smoking

If yes, Frequency: _____ Quantity: _____

Allergies

- ☐ Aspirin
- ☐ Latex
- ☐ Penicillin
- ☐ Other Allergies (List Below)

Medical Conditions

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma:
  - Required Hospitalization ☐
  - Have you used steroids? ☐
  - Date of Last Episode _____
- ☐ Blood Transfusion
- ☐ Blood Disease, Clotting Disorder
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or Bloody
- ☐ Diabetes: A1C _____ Date Taken _____
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis: Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Any Immune Deficiency
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Pregnant/Nursing: Due Date _____
- ☐ Radiation Treatments
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinusitis
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Sickle Cell Anemia
- ☐ Skin Rash
- ☐ Slow Healing Wounds
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth on Head and/or Neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, Unexplained
- ☐ Other Conditions (Explain Below)

Other Allergies: List all additional allergies you have below.

Other Conditions: List all additional conditions or information below.

Medications: List any medications you are taking below.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Premedication ☐ **Yes** ☐ **No**
Do you have to take pre-medication prior to receiving dental treatment? If Yes, please explain:

Anesthetic Allergy ☐ **Yes** ☐ **No**
Have you ever had an allergic reaction to Novocaine, local or general anesthetics? If Yes, please explain:

Joint Replacement ☐ **Yes** ☐ **No**
Have you had an orthopedic total joint (hip knee, replacement? If Yes, have you had any complications?

Bisphosphonates ☐ **Yes** ☐ **No**
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Boniva, Reclast, Prolia, Didronel, Zometa) for osteoporosis or Paget's Disease?

Do you use controlled substances (drugs)? ☐ Yes ☐ No
If Yes, please specify what how often below:

Do you drink alcoholic beverages? ☐ Yes ☐ No
If Yes, how much alcohol did you drink in the last 24 hours? _____
If Yes, how much do you typically drink in a week? _____

Have you ever had trouble from previous dental care? ☐ Yes ☐ No
If Yes, please explain:

Authorization and Release: I have read and answered the above questions to the best of my knowledge.

_____ _____
Patient or Guardian Signature Date

_____ _____
Doctor Signature Date

Last Name _____ First Name _____ Date of Birth _____

Privacy Policy

Notice of Information & Privacy Practices | HIPAA Communication Form

I have been given a copy of Renewal Family Dental, PLLC ("Practice"), *Notice of Information and Privacy Practices* **("Notice"), which describes how my health information is used and shared. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer at office@renewalfamilydental.com or by visiting the Practice's web site.**

Patient privacy is important to us. Our policy to keep patient health information confidential and not disclose such information without your consent or written authorization unless otherwise required by federal or state privacy laws.

Please provide names of individuals with whom we can communicate concerning you or your child's health information and care. This may include family members, friends, organizations, caregivers, and babysitters.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please note: If you have someone accompany you in the treatment area, we will assume this person is entitled to receive information regarding your care and we can freely discuss your health information.

Patient Communication - Our practice is to protect the privacy of our patients while ensuring our patients are kept well informed of their appointments and other information. As a service to our patients, we will communicate appointment reminders and other healthcare related and bill information via text message, email or phone. These messages may come from an automated notification system. In addition to the above healthcare messages, we will communicate with you through text message from an automated patient notification system regarding your dental bill, surveys regarding your dental care, services or products related to your dental care or other communications related to your dental care and our practice. Limited information will be left when leaving a voice message. Medical information will not be shared when leaving a voice message. Please inform our team if you would prefer that we use an additional communication preference for appointment reminders or other information related to your care. You are free to make changes to your preferences at any time by completing a new form.

My signature below acknowledges that I have been offered and/or provided with a copy of the Notice of Information and Privacy Practices. By providing us with your mobile number, you consent to receive these messages, including appointment reminders and other health-care related information by text message, voicemail, and email to the phone number(s) and email address that I have chosen to provide below:

Mobile Phone Number _____ Home Phone Number _____ Email Address _____

Print Name and/or Representative's Title (*e.g., Guardian, Executor of Estate, Health Care Power of Attorney)* _____

_____ _____

Last Name First Name Date of Birth

Patient or Guardian Signature Date

Last Name | First Name | Date of Birth

Financial Agreement

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All Patients must complete our "Patient Information Form" prior to being seen by the Dental Professional
- Full Payment is due at the time of service
- We accept CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT

Adult Patients

- Adult patients are responsible for payment in full at the time of service.

Minors Accompanied by an Adult

- The adult accompanying a minor, his/her parent, or guardians are responsible for payment in full at the time of service

Unaccompanied Minors

- The parents or guardians are responsible for payment in full at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized. Providers may choose to avoid treating a minor without an adult present at his or her own discretion.

Insurance

- This Practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of the service. This amount maybe subject to adjustment, when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services which can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of the dental services that exceed the particular plan's limitations. You are responsible for monitoring the amount of remaining benefits for any annual benefit period and may not rely upon any information provided by the staff regarding your remaining benefits in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to us. However, if you are paid by the insurance company instead of us, you then become responsible for the total account balance and payment is expected immediately.
- If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.
- You, as a patient, are always responsible for any charges that are not covered by your insurance.

NSF Fee

- All payment returned due to non-sufficient funds will be subject to an NSF fee of $25.00

Patient or Guardian Signature | Date

Patients, please keep this page for your records

Non-Discrimination Policy

Renewal Family Dental, PLLC complies with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Renewal Family Dental, PLLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If requested, Renewal Family Dental, PLLC will provide free aids and services to people with disabilities to communicate effectively with us, such as: Qualified interpreters or Written information in other formats (large print, audio, accessible electronic formats, other formats). If you need these services, please contact us.

If you believe that Renewal Family Dental, PLLC has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax or email with:

Renewal Family Dental, PLLC
22190 Garrison St., Suite 201
Dearborn, MI, 48124
313.277.8900 office@renewalfamilydental.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW; Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

ADA Rights and Responsibilities Statement

Patient Rights: You have a right to:

1. Choose your own dentist and schedule an appointment in a timely manner.
2. Know the education and training of your dentist and the dental care team.
3. Request to see the dentist every time you receive dental treatment, subject to any state law exceptions.
4. Have adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
5. Know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.
6. Receive an explanation of the purpose, probable (short and long term) results, alternatives and risks involved before consenting to a proposed treatment plan.
7. Be informed of continuing heath care needs.
8. Know in advance the expected cost of treatment.
9. Accept, defer, or decline any part of your treatment recommendations.
10. Have reasonable arrangements for dental care and emergency treatment.
11. Receive considerate, respectful, and confidential treatment by your dentist and dental team.
12. Expect the dental team members to use appropriate infection and sterilization controls.
13. Inquire about the availability of processes to mediate disputes about your treatment.
14. Receive access to treatment and accommodations that are available regardless of race, sex, age, creed, sexual orientation, national origin, religion, handicap, or marital status

Patient Responsibilities: You have a responsibility to / for:

1. Provide, to the best of your ability, accurate, honest, and complete information about medical history and current health status.
2. Report changes in your medical status and provide feedback about your needs and expectations.
3. Participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.
4. Inquire about treatment options and acknowledge the benefits and limitations of any treatment that you choose.
5. Consequences resulting from declining treatment or from not following the agreed upon treatment plan.
6. Keep your scheduled appointments.
7. Be available for treatment upon reasonable notice.
8. Adhere to regular home oral health care recommendations.
9. Assure that your financial obligations for healthcare are met.

Areas within practice may be limited to some requests for accommodations where sterile environment must be maintained

COVID-19 Pandemic Dental Treatment Consent and Release

We strive to provide a safe environment for our patients and staff, and to advance the safety of our community. However, the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. There are numerous ways in which the COVID-19 virus can be transmitted, including from surface contact, respiratory droplets and aerosols, or fine particles that travel with air currents. Dental procedures create aerosols, the amount of which depends on the type of procedure. While we are committed to providing the safest environment as possible for our patients, there can be no guaranty that our facility is completely free of the COVID-19 virus and that you will not be exposed to the virus while receiving dental treatment despite our efforts to minimize the risk of exposure.

By signing this Consent and Release in the space provided below, you hereby release, acquit, waive all claims against, and forever discharge the practice providing your treatment (the "Practice") and its owners, successors, assigns, affiliates, officers, directors, administrators, representatives, principals, agents, servants, dentists, employees, independent contractors, insurers, and attorneys (collectively with the Practice, the "Indemnified Persons"), of and from any and all claims, charges, demands, promises, acts, agreements, costs, damages, debts, obligations, actions, causes of action (including but not limited to all avoidance actions of any type), suits in equity, expenses, executions, judgments, levies, liabilities, losses, and attorneys' fees, of whatever kind or nature, whether legal or equitable, liquidated or unliquidated, fixed or contingent, direct or indirect, suspected or unsuspected, accrued or unaccrued, known or unknown, present or future, asserted or unasserted, based upon, arising out of, appertaining to, or in connection with your exposure to the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) or contracting coronavirus disease (COVID-19) as a result of or in connection with your entry into the Practice's office, receipt of dental treatment from the Practice or coming in contact with any Indemnified Person at or near the Practice's office, and all related costs, expenses, illness, or death you may suffer as a result.

The releases set forth and otherwise referenced herein shall be interpreted as broadly as possible and shall be completely binding and enforceable at law. You acknowledge that the releases and waivers provided for herein include all claims and/or costs, including but not limited to those you do not know or suspect to exist, and hereby waive all rights which may exist with regard to such claims and/or costs. You expressly waive the provisions of any federal, state, and local statute or regulation limiting release of unknown claims, including any statutory language stating as following: "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY, AND ANY SIMILAR LAW."

You agree that you have had the opportunity to consult with an attorney prior to executing this Consent and Release, that you voluntarily have signed the same and that you have read and understand this Consent and Release. **YOU FULLY UNDERSTAND THAT, BY SIGNING THIS CONSENT AND RELEASE, YOU ARE WAIVING IMPORTANT LEGAL RIGHTS.**

Patient:

Name: _____ DOB: _____

Signature: _____ Date: _____

For Parents/Guardians:

In addition to the foregoing, we/I further waive all claims against (to the same extent set forth above), and agree to hold harmless and indemnify, the Indemnified Persons and each of them, for any illness, death, costs, expenses, or other loss sustained by the Patient which results in any way from the Patient's entry into the Practice's office, receiving dental treatment, or coming in contact with any Indemnified Person at or near the Practice's office.

Parent's/Guardian's Signature (if Patient is under 18):

The undersigned is a parent(s) or legal guardian(s) of the Patient and hereby consents to the foregoing Waiver of Liability and agrees (1) on behalf of the Patient for Patient to be bound by the provisions hereof, and (2) on behalf of himself or herself and each other parent or guardian of the Patient, that all of the terms hereof, including all liability waived hereby, equally apply to and they are subject to each of them.

Name: _____

Signature: _____ Date: _____