PREFERRED DENTAL GROUP

CHILD ACQUAINTANCE INFORMATION

PATIENT INFORMATION

Date _____

Child's Name _____ (LAST / FIRST / MIDDLE) Preferred Name _____

Address _____ (STREET / CITY / ZIP) Home Phone _____

Birthday _____ School & Grade _____ Hobby or Sport _____

FAVORITE Toy _____ Person / Celebrity _____ Fictional Character _____

Parent's or Guardian's Name _____

How did you learn about our office? _____ If from a friend or relative, his/her name _____

RESPONSIBLE PARTY INFORMATION

Father's Name _____ (LAST / FIRST / MIDDLE) Marital Status _____

Residence _____ (STREET / CITY / STATE / ZIP) How Long _____

Previous Address (if > 3 years) _____ (STREET / CITY / STATE / ZIP)

Mailing Address _____ (STREET / CITY / STATE / ZIP)

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security No. _____ Birthdate _____

Employer _____ Occupation _____ No. of Years Employed _____

Mother's Name _____ (LAST / FIRST / MIDDLE) Marital Status _____

Residence _____ (STREET / CITY / STATE / ZIP) How Long _____

Previous Address (if > 3 years) _____ (STREET / CITY / STATE / ZIP)

Mailing Address _____ (STREET / CITY / STATE / ZIP)

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security No. _____ Birthdate _____

Employer _____ Occupation _____ No. of Years Employed _____

Who is financially responsible for the child? _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security No. _____

Insurance Company _____ Group Number _____ Local No. _____

Insur.Co. Address _____

Do you have dual coverage? ☐ YES ☐ NO If Yes -

Insured's Name _____ Insured's Social Security No. _____

Insurance Company _____ Group Number _____ Local No. _____

Insur.Co. Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearset relative not living with you _____

Complete Address _____ Phone _____

In order to protect my dental health, I authorize you to contact me by phone as needed. If I am on the national or state Do Not Call Registry, this authorization applies to time guidelines beyond those stated in the Do Not Call Registry(s).

CONSENT The undersigned hereby authorized Doctor to take images, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the patient indicated on this form, and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility of payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any blanace over sixty (60) days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

I understand that where appropriate, credit bureau reports may be obtained

Signature of Parent or Guardian _____ Date _____

Updates (date & initial) _____ _____ _____ _____ _____

PREFERRED DENTAL GROUP

Health History Form

Name:_____ Birth Date:_____

	Y	N	If yes, please explain:
Are you under a physician's care now?	☐	☐	
Have you ever been hospitalized or had a major operation?	☐	☐	
Have you ever needed to pre-med before an appointment?	☐	☐	
Are you taking any medications, drugs, or supplements?	☐	☐	
Do you take or have you ever taken Phen-Fen or Redux?	☐	☐	
Have you ever taken Fosamax, Actonel, or any other medications containing bisphosphonates?	☐	☐	
Are you on a special diet?	☐	☐	
Do you use tobacco?	☐	☐	
Do you use controlled substances?	☐	☐	

•Are you allergic to any of the following?

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Penicillin ☐ Sulfa Drugs
☐ Other_____ ☐ **No Known Medical Allergies**

•Women: Are you

Pregnant or trying to get pregnant? ☐ Y ☐ N Taking oral contraceptives? ☐ Y ☐ N Nursing? ☐ Y ☐ N

•Do you have or have you had any of the following?

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Recent Weight Loss	☐	☐
Alzheimer's	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Renal Dialysis	☐	☐
Anaphylaxis	☐	☐	Eating Disorder	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	High Cholesterol	☐	☐	Rheumatism	☐	☐
Angina	☐	☐	Epilepsy	☐	☐	Hives or Rash	☐	☐	Scarlet Fever	☐	☐
Arthritis/Gout	☐	☐	Excessive Bleeding	☐	☐	Hypoglycemia	☐	☐	Seizures/Convulsions	☐	☐
Artificial Heart Valve	☐	☐	Excessive Thirst	☐	☐	Irregular Heartbeat	☐	☐	STIs	☐	☐
Artificial Joint	☐	☐	Fainting Spells	☐	☐	Jaundice	☐	☐	Shingles	☐	☐
Asthma	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Sickle Cell Disease	☐	☐
Blood Disease	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Sinus Trouble	☐	☐
Blood Transfusion	☐	☐	Frequent Dry Mouth	☐	☐	Liver Disease	☐	☐	Spina Bifida	☐	☐
Breathing Problems	☐	☐	Frequent Headaches	☐	☐	Low Blood Pressure	☐	☐	Stomach/Intestinal Disease	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Lung Disease	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Mental Health Concerns	☐	☐	Swelling of Limbs	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease	☐	☐
Chest Pains	☐	☐	Heart Attack	☐	☐	Osteoporosis	☐	☐	Tonsilitis	☐	☐
Cold sore/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Tumors or Growths	☐	☐
Congenital Heart Disorder	☐	☐	Heart Disease or Heart Trouble	☐	☐	Pain in Jaw Joints	☐	☐	Ulcers	☐	☐
Cortisone Treatment	☐	☐	Hemophilia	☐	☐	Parathyroid Disease	☐	☐	If you have any other medical conditions, please list them in the comments.		
Diabetes	☐	☐	Hepatitis A	☐	☐	Radiation Treatment	☐	☐			

If you have diabetes, what was your most recent A1C and/or FBG? _____

Comments: _____

_____

Patient/Guardian Signature _____ **Date** _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to this patient's health. It is my responsibility to inform the office of any medical changes.

PREFERRED
DENTAL GROUP
38000 Ann Arbor Trail, Livonia MI 48150 734-591-3636

Revised Date: **2 May 2018**

MEMORANDUM FOR: Record

SUBJECT: Patient Acknowledgement and Consent Form

1. Effective April 14 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

   To comply with one of HIPPA requirements we will give you a copy of our Notice of Privacy Practices. This notice of Privacy Practices contains the Information that HIPPA requires us to disclose regarding our privacy practice.

Patient Acknowledgement

I acknowledge that a copy of the Notice of Privacy Practice has been made available to me today.

Patient name	Patient Signature	Date

FOR OFFICE USE ONLY

Patient refused to sign.

The following circumstances prohibited the patient from signing the acknowledgement

An emergency situation prevented the patient from signing the acknowledgement.

Staff Member Name	Staff Signature	Date

Patient Consent

I consent to your disclosures of my information, which you deem necessary in connection with my treatment.

I understand that such disclosures may not be of the type listed above.

Patient Name	Patient Signature	Date

PREFERRED DENTAL GROUP

Welcome- to be able to care for you, current information is important. Please update the following and also please indicate your preference.

Please update the following:

Name: _____

Cell Phone number: _____

Email Address: _____