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 this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information

Today's Date: _____

Name: _____ Nickname: _____ Date of Birth: _____ Sex: _____

Address: _____ City, State, Zip: _____

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

E-mail: _____

Check appropriate box: Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Other [ ]

Referred to our office by: _____

Responsible Party Information

Name of Responsible Party: _____ Social Security #:_____

Address (if different than patient):_____ City, State, Zip: _____

Occupation: _____ Employer: _____

Employer's Address: _____ Phone: _____

Responsible Party's Spouse

Name of Responsible Party: _____ Social Security #:_____

Address (if different than patient):_____ City, State, Zip: _____

Occupation: _____ Employer: _____

Employer's Address: _____ Phone: _____

Dental Insurance Information

Insurance Company _____ Insured Name _____

Insured DOB: _____ Relationship to Patient: _____ Subscriber #:_____

Group #:_____ Employer: _____

Insurance Co. Address: _____ Phone: _____

Secondary Dental Insurance Information

Insurance Company: _____ Insured Name: _____

Insured DOB: _____ Relationship to Patient: _____ Subscriber #: _____

Group #: _____ Employer: _____

Insurance Co. Address: _____ Phone: _____

Patient Medical History

General Health: Good [ ] Fair [ ] Poor [ ]

Physician: _____ Office Phone: _____ Date of Last Exam: _____

Are you currently on any prescription or over the counter medications, vitamins, nutritional or herbal supplements?

Yes [ ] No [ ] If "Yes" please list: _____

***Are you allergic to any medications*? Yes [ ] No [ ] If "Yes" please circle or list:**

Penicillin Codeine Latex Local Anesthetics Sulfa Drugs Barbiturates Sedatives Iodine Aspirin Any Metals
Other: _____

Please mark the ones that apply to you and your Medical History.

[ ] Need antibiotic coverage prior to dental work?

[ ] Artificial joint replacement or Implant?

[ ] Undergone Radiation or IV Chemotherapy?

[ ] Use or have used tobacco products?

[ ] Subject to prolonged bleeding?

[ ] Family history of Diabetes?

[ ] Excessive thirst and/or urination?

[ ] Recent unusual weight loss?

[ ] Subject to fainting?

[ ] Recently hospitalized or past major surgeries?

[ ] Women Currently pregnant? _____ How far? _____

[ ] Women Currently nursing? _____

Please circle Y or N individually for each question:

Y	N	High or Low Blood Pressure	Y	N	Heart Disease	Y	N	Osteoporosis
Y	N	Heart Attack	Y	N	Cardiac Pace Maker	Y	N	Chest Pains
Y	N	Rheumatic Fever	Y	N	Heart Murmur	Y	N	Long-Term Steroid Treatment
Y	N	Swollen Ankles	Y	N	Artificial Heart Valves	Y	N	Scarlet Fever
Y	N	Fainting/Seizures	Y	N	Frequently Tired	Y	N	Tuberculosis
Y	N	Asthma	Y	N	Anemia	Y	N	Glaucoma
Y	N	Epilepsy/Convulsions	Y	N	Emphysema	Y	N	Liver Disease
Y	N	Leukemia	Y	N	Cancer (type :_____)	Y	N	Hemophilia
Y	N	Diabetes (type:_____)(A1C:_____)	Y	N	Arthritis/Rheumatism	Y	N	Respiratory Problems
Y	N	Kidney Disease	Y	N	Jaundice/Hepatitis (type:_____)	Y	N	Mitral Valve Prolapse
Y	N	AIDS/HIV Infection	Y	N	Sexually Transmitted Disease	Y	N	Eating Disorders
Y	N	Thyroid Problem	Y	N	Stomach Troubles/Ulcers	Y	N	Neck or Back Problems

Do you have any other medical or health condition which is not listed?

[ ] Yes [ ] No If "Yes" please list: _____

Signature: _____ Date: _____ Staff: _____

Dental Health and Wellness Center, PLLC

755 W. Big Beaver Rd. #250
Troy, MI 48084

Dr. Michael Szewczyk, DDS
Dr. Teresa A. Gorski, DDS

7433 Michigan Ave.
Detroit, MI 48210

AUTHORIZATION TO DISCLOSE PROTECTED PATIENT INFORMATION

It is the office policy of Dental Health and Wellness Center, PLLC to not release medical, personal or otherwise confidential and/or unauthorized information by any method. **If you would like to have information released to someone other than yourself** (specifically information such as confirmation of your scheduled appointments, prescription information, billing/insurance information or any other information regarding your dental care), please complete the following:

I, _____, currently residing at _____,
(Name) (Address)

Name the following people as individuals who are authorized to receive medical, billing and insurance information pertinent to my care from the offices of Dental Health and Wellness Center, PLLC:

Spouse: _____

Parent: _____

Other: _____ Relationship: _____

In addition, I authorize the offices of Dental Health and Wellness Center, PLLC to leave messages regarding information pertaining to me by the following methods and **will assume responsibility to notify the office whenever this information changes**:

(Please Circle)

Home Phone: (_____) - _____ - _____ Yes No

Cell Phone: (_____) - _____ - _____ Yes No

Work Phone: (_____) - _____ - _____ Yes No

AUTHORIZATION OF HEALTH RECORDS RELEASE AND INSURANCE PAYMENT

I, _____ authorize the dentist to release any information including diagnosis and records of any treatment or examination recorded on me or my child during the period of each dental care to **third party payers and/or other health practitioners** (i.e. referrals, medical emergency).

I, _____ authorize and request my **insurance company** to pay directly to Teresa A. Gorski DDS, PC, Michael Szewczyk DDS, PLLC, or any other dentist working for Dental Health and Wellness Center, otherwise payable to me.

_____ _____

(Signature of Patient/Responsible Party) (Date)

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Please initial next to each ⋗ to indicate your understanding and consent of the following policies.

PAYMENT POLICY

Due to the increasing cost of statement preparation mailing, we ask that all fees for dental services rendered be paid at time of service. All patients needing extensive dental treatments may request a free treatment cost estimate. After discussing the treatment plan with the doctor and making appoints for planned treatment, we ask that you make definite financial arrangements with our front desk personnel. Payment can be made by cash, check (payable to Dental Health and Wellness Center), or credit card (Visa and Master Card). ⋗ _____

All services rendered that involve laboratory costs such as crown, bridges, partial and full dentures, etc. require a 50% deposit on the start date, and must be paid in full by the time of delivery. ⋗ _____

Patients who frequently and continuously refuse to pay for services over an extended period of time shall be denied services until their financial obligation is met. ⋗ _____

Due to the many frequent changes in insurance policies and various contracts, it is no longer an easy task to interpret each individual's policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you the patient to please check with your insurance company prior to initiation of treatment. **It is your responsibility to know your individual coverage.** ⋗_____

As always, for your convenience we process the necessary forms to receive insurance payments. We will do our best to estimate the insurance portion at the time of treatment. Where the estimate differs from the actual payment, and the patient feels short-changed by the insurance company, we urge the patient to contact their employer. Our office is prepared to aid our patients with any dental information necessary to help maximize their insurance coverage. However, financial obligations and the understanding of the dental insurance plan rest with the patient. ⋗ _____

Your insurance is the result of a contract between your employer and the insurance company. Most policies cover a portion of the bill. There are deductibles and percentage allowances. Most insurance companies set their own usual and customary fee and they vary from company to company, and even individual contracts within the same company. Our charges are the same for everyone. **The difference between our bill and the insurance payment is the patient's responsibility.** ⋗ _____

Some insurance companies have history of inconsistent or unpredictable reimbursement policies. In these cases, the patient will be asked to pay our office for the entire dental bill and receive reimbursement directly from the insurance company. ⋗ _____

LATE CHARGES

If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and carried will be assessed each month. If I fail to keep this account current, Dental Health and Wellness Center will be unable to provide additional dental services except dental emergencies, or where there is pre-payment of this account. I agree to pay collection cost and reasonable attorney fees on this account or any future outstanding account balances.

_____ _____

(Signature of Patient/Responsible Party) (Date)

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INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept to reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of recommended procedure, alternative treatments, or the option of no treatment.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly risks and complications of treatment include, but are not limited to, the following:

- Pain, swelling, and discomfort after treatment
- Infection in need of medication, follow-up procedures or other treatment
- Temporary, or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with the possible loss of taste
- Damage to adjacent teeth, restorations or gums
- Possible deterioration of your condition which may result in tooth loss
- The need or replacement of restorations, implants, or other appliances in the future
- An altered bite in need of adjustment
- Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist
- A root tip, bone fragment, or piece of a dental instrument may be left in your body and may have to be removed at a later time if symptoms develop
- If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment
- Allergic reaction to anesthetic or medication
- Need for follow-up care and treatment, including surgery

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking, antibiotics.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above.

_____ _____

(Signature of Patient/Parent/Legal Guardian) (Date)