ALPHA DENTAL CENTER

(877) 764-5387
alphadentalcenters.com
21120 Allen Road, Woodhaven, MI 48183

Patient Questionnaire

What is your major dental complaint?

_____

Date _____

MEDICAL HISTORY		
PHYSICIANS NAME	**ADDRESS**	**TELEPHONE**

GENERAL QUESTIONS	Y	N	SPECIFICS
Are you in good health?			
Are you under medical treatment?			
Are you taking medicine regularly? If so, please list medication.			
Have you been hospitalized within the last 5 years? If so, why?			
Have you ever had excessive bleeding requiring special treatment?			
Are you taking coumadin (blood thinner)?			
Do you have a pacemaker?			
Have you had heart surgery or trouble?			
Have you ever needed to be premedicated for any reason?			
Have you ever been diagnosed or exposed to the AIDS virus?			

DO YOU HAVE/EVER HAD?	Y	N		Y	N		Y	N
Heart Murmur			Hepatitis			Jaundice		
High or Low Blood Pressure			Cancer or Tumor Treatment			Stroke		
Diabetes			Rheumatic Fever or Scarlet Fever			Psychiatric Treatment		
Tuberculosis or Lung Disease			Bleeding Problems			VD (Syphilis, Gonorrhea)		
Heart Disease or Lesions			Asthma or Hay Fever			Other		
Epilepsy			Arthritis			Other		

MEDICAL CONDITIONS	Y	N	SPECIFICS
Do you have any medical conditions that we should know about?			

ARE YOU ALLERGIC TO ANYTHING?	Y	N		Y	N		Y	N
Penicillin and Other Antibiotics			Tranquilizers, Sedatives			Fluoride		
Sulfa Drugs			Aspirin			Other		
Local Anesthetics			Iodine			Other		
Barbiturates			Codeine			Other		

WOMEN PLEASE	Y	N	SPECIFICS
Are you pregnant? If so, when are you due?			

DENTAL HISTORY			
ARE YOU BOTHERED WITH THE FOLLOWING SYMPTOMS?	**Y**	**N**	**SPECIFICS**
Bleeding Gums			
Tenderness when chewing			
Bad Breath			
Pain in or near the ears			
Popping or clicking of the jaw			
Sensitivity to heat, cold or sweets			

GENERAL QUESTIONS	Y	N	SPECIFICS
Have you been treated by a Periodontist?			
Have you been treated by an Orthodontist?			
Have you received instructions in the care of your teeth?			
Do you wish to maintain your own teeth and avoid dentures?			

DATE YOU LAST VISITED DENTIST	PURPOSE

Signature _____ **Date** _____

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Patient Information

Whom may we thank for referring you to our office?

_____

Date _____

PATIENT INFORMATION			
NAME		SOCIAL SECURITY	BIRTH DATE
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	CELL PHONE	
E-MAIL ADDRESS	COLLEGE STUDENT (CIRCLE)	SCHOOL NAME	
	YES NO FULL TIME PART TIME		
EMERGENCY CONTACT		PHONE NUMBER	
SPOUSE'S NAME		BIRTH DATE	

NAME	RELATIONSHIP	SOCIAL SECURITY	BIRTH DATE
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	CELL PHONE	
E-MAIL ADDRESS	DRIVER'S LICENSE	IS THIS PERSON A PATIENT IN OUR OFFICE?	
		YES	NO

PRIMARY INSURANCE			
NAME OF INSURED	SOCIAL SECURITY NUMBER	RELATIONSHIP	BIRTH DATE
HOME PHONE	CELL PHONE	WORK PHONE	
EMPLOYER	ADDRESS		
INSURANCE CARRIER	CONTRACT NUMBER	GROUP NUMBER	
PHONE NUMBER	ADDRESS		

SECONDARY INSURANCE			
NAME OF INSURED	SOCIAL SECURITY NUMBER	RELATIONSHIP	BIRTH DATE
HOME PHONE	CELL PHONE	WORK PHONE	
EMPLOYER	ADDRESS		
INSURANCE CARRIER	CONTRACT NUMBER	GROUP NUMBER	
PHONE NUMBER	ADDRESS		

Signature _____ **Date** _____

Payment in full is expected at the time of service. For your convenience, we accept many methods of payment: Cash/check (discounts may apply for prepayment), Credit Cards (Visa, Mastercard, Discover and American Express) and Care Credit (ask for information on interest free loans!).

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My Medication List

Date _____

PATIENT INFORMATION		
NAME		
DOCTOR	**PHONE NUMBER**	**FAX**
PHARMACY	**PHONE NUMBER**	**FAX**

MEDICATION

Please list below all prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers, and homeopathic remedies.

MEDICATION NAME	DOSE	WHEN TAKEN	REASONS FOR TAKING

ALLERGIES AND REACTIONS	
NAME	**REACTION**

Signature _____ **Date** _____

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Information Request Form

Date _____

PATIENT INFORMATION

NAME			
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
PHONE	**E-MAIL ADDRESS**		

REQUESTED INFORMATION OR SERVICE

PLEASE PRINT YOUR ANSWER BELOW

OFFICE USE ONLY

FOLLOW UP	Y	N	DATE
Information Follow Up by Office			

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Patient Referral Form

Date _____

PATIENT INFORMATION

NAME			
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
PHONE	**E-MAIL ADDRESS**		

REFERRAL INFORMATION

NAME (OF REFERRAL)			
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
PHONE	**E-MAIL ADDRESS**		

OFFICE USE ONLY

CONTACT	Y	N	DATE
Contacted by Office			

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Authorization to Bill Insurance Carrier and Agreement to Pay for Services

Date _____

I authorize and hereby request my insurance company to pay directly to **Alpha Dental Center** and insurance benefits otherwise payable to me.

_____
initial

I understand, and agree that **Alpha Dental Center** will, as a courtesy, bill my insurance company for services performed in their office. I further understand, that my dental carrier may pay less than the actual bill for services, and I agree to be financially responsible for all of the services performed for:

_____
name

I understand, and agree that my insurance benefits are estimates only, based on the information available at the time, and are in no way a guarantee of payment.

_____
initial

I understand, and agree that payment in full is expected at each appointment, and my choice of payment options have been explained to me. My preferred method of payment for today's visit will be:

_____ cash/check _____ credit card _____ care credit

Signature _____ **Date** _____

I understand, and agree that if any outside collection becomes necessary, I will be responsible for any and all fees incurred in doing so.

I understand, and agree that **Alpha Dental Center** has the right to charge me $40.00 for any appointments that I fail to keep without providing the office with at least a 24 hour notification of cancellation.

Signature _____ **Date** _____

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Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Date _____

I, _____, understand that as part of my healthcare, **Alpha Dental Center** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among other health professionals who may contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals
- A means with which to assist in our patient communication by providing reminders of upcoming appointments, the need to schedule an appointment, etc. through telephone calls, answering machine messages, and/or postal reminders.

I understand and have been provided with a *Notice of Information Practices (January 2003)* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

I understand that **Alpha Dental Center** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **Alpha Dental Center** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the code of Federal Regulations. Should **Alpha Dental Center** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail). I wish to have the following restrictions to the use or disclosure of my health information: *(Examples – restrictions on: which family members we may communicate with regarding your care, making reminder calls, sending reminder notices, who may approve treatment for minors, etc.)*

_____

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept/decline the terms of this consent.

Signature _____ **Date** _____

For Office Use Only

☐ Consent received by _____ on _____ .
☐ Consent refused by patient, and treatment refused as permitted.
☐ Consent added to the patient's medical record on _____ .

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Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Date _____

I, _____
patient's name

_____
address

_____
city, state, zip code

_____
date of birth

hereby authorize:

_____
physician's name

_____
address

_____
city, state, zip code

to release any information in my medical records relating to my diagnosis and treatment history for sleep disorders and sleep disordered breathing to:

Alpha Dental Center
21120 Allen Road
Woodhaven, MI 48183
Telephone: (877) 764-5387
Fax: (734) 675-7128

to assist in the evaluation of my suitability for treatment of sleep disordered breathing.

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating physician or dentist. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims.

Signature _____ **Date** _____

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Patient Consent to an Oral Cancer Screening

Date _____

Alpha Dental Center strives to give you the best possible care. We recommend an oral cancer screening once (1) a year for non-At-Risk patients and twice (2) a year for "At-Risk patients." The VELscope is a screening tool to help assist in oral cancer screening. It is at a low cost of $25.00, which we will bill to your insurance; however, they may or may not cover depending on your insurance contract.

Approximately 25% of oral cancer cases have NO known risk factors.

At-Risk Patients include the following:

- Family history of cancer
- More common in men than women
- More common in African Americans
- Greater risk after age 35
- History of tobacco use (past and/or present)
- Consumption of alcohol
- Substance abuse / Use of recreational drugs
- Eating disorder
- Prolonged exposure to sunlight (lip cancer)
- The sexually transmitted infection Human Papillomavirus (HPV)

☐ YES, I wish to have this done.

☐ NO, I do NOT wish to have this done.

Print Name _____

Signature _____ **Date** _____