Pointe Dental Group

REGISTRATION FORM

Section I: Patient Information Date_____

Name:_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ Social Security Number:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School_____ City/State_____ ☐ FT ☐ PT

Spouse or Parent's Name:_____ Employer_____ Work Phone_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____ Relationship to Patient: _____

Address:_____

City:_____ State:_____ Zip:_____ Phone: (_____)_____

Employer_____ Work Phone (____)_____ SSN#_____

Driver License#_____

Insurance Information

---------- **PRIMARY INSURANCE**----------

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (_____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

---------- **SECONDARY INSURANCE**? ☐ Yes ☐ No IF **YES**, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (_____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

For Insurance Assignment:

I AUTHORIZE RELEASE ON *ANY* INFORMATION RELATING TO THIS OR FUTURE DENTAL CLAIMS, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____ _____

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you been a patient in the hospital during the past two years? ..... YES NO
4. Have you been under the care of a physician during the past two years? ..... YES NO
   For _____
   Physician's Name _____ Phone #_____
5. Have you taken any medicine or drugs during the past two years? ..... YES NO
   If yes, please list: _____
6. Are you aware of being allergic to any medications or substance? ..... YES NO
   If yes, please list:_____
7. Circle any previous or present condition:

A. AIDS	I. Heart Problem	P. Rheumatic Fever
B. Arthritis	J. Hepatitis	Q. Sexually Transmitted Disease
C. Asthma	K. High Blood Pressure	R. Stroke
D. Cancer	L. Artifical Joints	S. Tuberculosis
E. Diabetes	M. Kidney Problems	T. Other Diseases
F. Epilepsy	N. Low Blood Pressure	
G. Glaucoma	O. Nervous Breakdown or Psychiatric Therapy	
H. Heart Murmur or Mitral Valve Prolapse		

If you circled either I or T describe condition:
_____
_____

8. Have you, or are you currently taking **Fosamax, Fosamax+D, Actonel, Actonel+Ca, Skelid, Didronel, Boniva, Reclast, Aredia, Zometa or any other bisphonshonate** medication (osteoporosis or cancer treatment medication)? ..... YES NO
9. Has your medical doctor ever told you, you have a cancer or tumor?..... YES NO
10. Have you ever had a skin rash or other reaction to metal jewelry? To what? _____ YES NO
11. Do you take or have been told you need to take premedication before dental treatment?..... YES NO

FOR WOMEN ONLY:
Are you pregnant? YES/NO If yes, what month? _____ Are you taking birth control pills? YES /NO

THE ABOVE INFORMATION IS TRUE AND ACKNOWLEDGE RECEIPT OF PRIVACY PRACTICES NOTICE

Patient Signature:_____ Date _____/_____/_____

CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, 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 (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for 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 1 ½ % finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest in the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature:_____ Date ___/____/_____ Witness _____

Parent or Responsible Party _____Relationship to Patient_____

AUTHORIZATION FOR DISCLOSURE OF PATIENT MEDICAL INFORMATION

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

ADDRESS _____ **SOC SEC #:** **XXX-XX-**_____

_____

_____

I HERBY AUTHORIZE USE OR DISCLOSURE OF PROTECTED HEALTH INFORTMATION ABOUT ME AS DESCRIBED BELOW:

FROM:

POINTE DENTAL GROUP
50505 SCHOENHERR, STE. 170
SHELBY TOWNSHIP, MI 48315
(586) 803 – 8300

POINTE DENTAL GROUP
18342 MACK AVENUE
GROSSE POINTE FARMS, MI 48236
(313) 881 - 2480

TO: **(NAME OF THE PERSON(S) YOU ARE ALLOWING POINTE DENTAL GROUP TO SHARE INFORMATION WITH)**

1. _____

2. _____

3. _____

4. _____

INFORMATION YOU WOULD LIKE DISCLOSED (check all that apply):

- o **BILLING/INSURANCE INFORMATION**
- o **APPOINTMENT/TREATMENT INFORMATION**
- o _____

I UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED MAY BE SUBJECT TO RE-DISCLOSURE BY THE ENTITY RECEIVING IT AND WILL NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IF THE REVOCATION IS IN WRITING, EXCEPT IF:

- **THIS OFFICE HAS TAKEN ACTION RELIANT UPON AUTHORIZATION**
- **THIS AUTHORIZATION WAS GIVEN AS A CONDITION OF OBTAINING INSURANCE COVERAGE**

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION BY DELIVERING WRITTEN NOTICE.
THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE SIGNED.

_____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE **DATE**

_____ _____
SIGNATURE OF WITNESS **DATE**