NORTHERN
FAMILY DENTAL

Brian R. Kwapisz, DDS
ph: 231 547 4148
fax: 231 547 5670

PATIENT LAST NAME ______________________ **FIRST** ______________________ **INITIAL** ____________

How do you wish to be addressed? ______________________ Date of Birth ______________

Address ______________________ City ______________ State ________ Zip ____________

Telephone (Mobile) ______________ (Work) ______________ (Home) ______________

Email ______________________ SS# ______________________

How did you hear about our practice? ______________________

Spouse's Name ______________________

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber Name ______________	Subscriber Name ______________
Subscriber ID ______________	Subscriber ID ______________
Date of Birth ______________	Date of Birth ______________
Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name ______________	Employer Name ______________
Employer Phone ______________	Employer Phone ______________
Insurance Company ______________	Insurance Company ______________
Insurance Group ______________	Insurance Group ______________
Insurance Phone ______________	Insurance Phone ______________

EMERGENCY CONTACT

Last Name ______________________ First ______________________ Initial ________

Telephone (☐ Mobile ☐ Work ☐ Home) ______________________

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by Dr. Brian R. Kwapisz and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to Dr. Brian R. Kwapisz and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

PATIENTS WHO ARE NOT COVERED BY DENTAL

All charges are expected to be paid in full at the time the dental services are rendered. Payment can be made by cash, check, VISA or MasterCard. If you ever have any questions about fees, please ask.

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

Signature ______________________________ Date ______________
(Responsible Party if under 18)

PATIENT REGISTRATION

PLEASE NOTE: When appointment time is reserved for you, it is reserved for you alone. **WE REQUEST 24 HOUR NOTICE IF YOU ARE UNABLE TO BE HERE.**

PLEASE COMPLETE ALL INFORMATION - THANK YOU

PATIENT LAST NAME______________________________ **PATIENT FIRST NAME** ______________________________

DENTAL HISTORY

Reason for today's visit______________________________ Date of last dental visit ______________

Former Dentist______________________________ Date of last dental x-ray______________

Please check if you have/had:	Yes	No		Yes	No
Bad Breath	☐	☐	Head, neck, jaw pain or aches	☐	☐
Blisters on lips or mouth	☐	☐	Lip or cheek biting	☐	☐
Burning sensation on tongue	☐	☐	Loose teeth or broken fillings	☐	☐
Chew on one side of mouth	☐	☐	Mouth breathing	☐	☐
Cigarette, pipe or cigar smoking	☐	☐	Orthodontic treatment	☐	☐
Smokeless tobacco	☐	☐	Nitrous Oxide	☐	☐
Dry mouth	☐	☐	Periodontal treatment	☐	☐
Food collection between teeth	☐	☐	Sensitivity to pressure or irritants	☐	☐
Clench or grind teeth	☐	☐	(cold, heat, sweets)		
Growths or sore spots in your mouth	☐	☐	How often do you floss? ______________		
Gums swollen, tender or bleeding	☐	☐	How often do you brush? ______________		

Have you ever had an allergic reaction to Novocaine, Local, or general anesthetics? ☐ Yes ☐ No

If yes, please explain ______________________________

____

____

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

____

____

MEDICAL HISTORY

Physician's name______________________________ Date of last visit______________

Physician's address______________________________ Blood Pressure______________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, please describe______________________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates______________________________

(Women) Are you pregnant? ☐ Yes ☐ No Due date______________ Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	☐	☐	Heart problems	☐	☐	Swelling of feet or ankles	☐	☐
Anemia	☐	☐	Hepatitis type ______________	☐	☐	Thyroid problems	☐	☐
Arthritis, Rheumatism	☐	☐	Herpes	☐	☐	Tonsillitis	☐	☐
Artificial heart valves	☐	☐	High blood pressure	☐	☐	Tuberculosis	☐	☐
Artificial joints	☐	☐	Any immune deficiency	☐	☐	Tumor or growth on head/neck	☐	☐
Asthma	☐	☐	Jaundice	☐	☐	Ulcer	☐	☐
Blood thinners	☐	☐	Kidney disease	☐	☐	Venereal disease	☐	☐
Bleeding abnormally with operations or surgery	☐	☐	Low blood pressure	☐	☐	Weight loss, unexplained	☐	☐
Blood disease, clotting disorders	☐	☐	Mitral valve prolapse	☐	☐	Do you wear contact lenses?	☐	☐
Cancer	☐	☐	Osteoporosis	☐	☐	Do you consume alcoholic beverages?	☐	☐
Chemical dependency	☐	☐	Osteopenia	☐	☐	Are you currently under the care of a Physician?	☐	☐
Chemotherapy	☐	☐	Pacemaker	☐	☐	Are you allergic/sensitive to Latex?	☐	☐
Circulatory problems	☐	☐	Radiation treatments	☐	☐	Allergic to Penicillin, Aspirin or other drugs?	☐	☐
Cortisone treatments	☐	☐	Respiratory disease	☐	☐	*If yes, please specify* ______________		
Cough, persistent or bloody	☐	☐	Rheumatic fever	☐	☐	______________		
Diabetes	☐	☐	Scarlet fever	☐	☐	______________		
Emphysema	☐	☐	Shortness of breath	☐	☐	______________		
Epilepsy	☐	☐	Sinus trouble	☐	☐	List any medications that you are taking:		
Fainting	☐	☐	Sickle cell anemia	☐	☐	______________		
Glaucoma	☐	☐	Skin rash	☐	☐	______________		
Headaches	☐	☐	Slow healing wounds	☐	☐	______________		
Heart murmur	☐	☐	Stroke	☐	☐	______________		

AUTHORIZATION AND RELEASE

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

Patient/Guardian Signature______________________________ Date______________

Reviewed by:______________________________ Date______________

DENTAL & MEDICAL HEALTH HISTORY

HIPAA Acknowledgement and Consent Form

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

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. This is <u>not</u> a change in our policies, but rather a formal declaration of them, as required under HIPAA.

Additionally, Michigan Law requires us to first obtain your written consent prior to disclosing any of your health information except for our disclosure in connection with: a defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; and/or a licensure investigation.

From time to time it may be necessary for us to make disclosures of your health information in connection with treatment. For example, we may make a referral to our consult with another dentist or health care professional or otherwise make disclosures of your health information in connection with providing or coordination treatment.

Patient Acknowledgement

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient Signature

____

Date

____

Welcome to Northern Family Dental

We are glad you made an appointment for yourself or your child for important oral health care. Regular dental visits every 6 months, including examinations, cleanings, fluoride treatment, dental sealants, and fillings are important to keep teeth healthy. It is especially important that you keep your appointment! Valuable time has been reserved for you or your child's care. A missed appointment results in lost time which could be used for another patient waiting to receive treatment.

BROKEN APPOINTMENT/CANCELLATION POLICY

If you fail to show for a scheduled appointment, all future appointments you may have scheduled will be cancelled. If you wish to continue your dental treatment in our office, you must call to schedule a new appointment. We also require 24 hour advance notice when cancelling an appointment that has been reserved for you. Depending on the nature of the cancellation, any combination of failing to give adequate cancellation notice or not showing for an appointment may result in DISMISSAL from Northern Family Dental if you fail to keep your scheduled appointment and/or a fee of $50 per scheduled hour.

APPOINTMENT REMINDER

Northern Family Dental provides TWO courtesy reminder calls for appointments approximately one week in advance as well as two days in advance. We will leave an appointment reminder voicemail with the phone number on file. However, in the event your phone has been disconnected or is unable to accept voicemail messages, it can result in the assessment of fees and/or DISMISSAL from Northern Family Dental if you fail to keep your scheduled appointment.

EMERGENCY CARE

Northern Family Dental clients who have been dismissed from the practice for either broken appointment or cancellation reasons will be notified by mail and will be seen for EMERGENCY care only for 30 days from the date of dismissal letter.

____________________ ____

Date Signature of Client (parent or guardian)

____________________ ____

Date Witness