

Patrick M. Michel, DMD, PA
PATIENT REGISTRATION

Date: _____

Patient Name: _____ Preferred Name: _____
FIRST MI LAST

Patient Address: _____ Birth Date: _____

City, State, Zip: _____

Soc Sec #: _____ Driver's License: _____

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

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Email Address: _____ I would like to receive correspondence via email.

Place of Employment: _____

Address of Employer: _____
STREET CITY STATE ZIP

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time Not a Student

Preferred Appointment Times: Morning Afternoon Any time

Monday Tuesday Wednesday Thursday

How did you hear about us? _____

Responsible Party (if someone other than patient):

Name (First, MI, Last): _____ Birth Date: _____

Address: _____ Social Security Number: _____

City, State, Zip: _____ Driver's License: _____

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

Primary Insurance Information:

Name of Insured: _____ SS# _____ Birth Date: _____

Relationship to Patient: Self Spouse Child Other

Employer: _____ Ins Company: _____

Emp Address: _____ Ins Address: _____

Emp City, State, Zip: _____ Ins City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ SS# _____ Birth Date: _____

Relationship to Patient: Self Spouse Child Other

Employer: _____ Ins Company: _____

Emp Address: _____ Ins Address: _____

Emp City, State, Zip: _____ Ins City, State, Zip: _____

Patrick M. Michel, DMD, PA

Medical History

Patient: _____

Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

For new patients: Date of last dental visit: _____ Date of last dental x-rays: _____
Reason for this visit: _____

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Do you use controlled substances? Yes No If yes, what kind?: _____

Have you ever had complications following dental treatment? Yes No If yes, please explain: _____

Women, are you...

Pregnant or trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Do you use tobacco? Yes No If yes, what kind?: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Are you taking any meds to improve your bone density? Yes No If yes, what kind?: _____

Are you allergic to any of the following? No allergies

Aspirin Penicillin Codeine Acrylic Metal Latex Local anesthetics Other: _____

Please mark all of the following you currently have or have had in the past.

<input type="radio"/> AIDS	<input type="radio"/> Cortisone Medicine	<input type="radio"/> High Blood Pressure	<input type="radio"/> Shingles
<input type="radio"/> Alzheimer's	<input type="radio"/> Diabetes type: _____	<input type="radio"/> Hives or Rash	<input type="radio"/> Sickle Cell Disease
<input type="radio"/> Anaphylaxis	<input type="radio"/> Drug Addiction	<input type="radio"/> Hypoglycemia	<input type="radio"/> Sinus Trouble
<input type="radio"/> Anemia	<input type="radio"/> Easily Winded	<input type="radio"/> Irregular Heartbeat	<input type="radio"/> Spina Bifida
<input type="radio"/> Angina	<input type="radio"/> Emphysema	<input type="radio"/> Kidney Problems	<input type="radio"/> Stomach/ Intestinal Disease
<input type="radio"/> Arthritis/Gout	<input type="radio"/> Epilepsy or Seizures	<input type="radio"/> Leukemia	<input type="radio"/> Stroke
<input type="radio"/> Artificial Heart Valve	<input type="radio"/> Excessive Bleeding	<input type="radio"/> Liver Disease	<input type="radio"/> Thyroid Disease
<input type="radio"/> Artificial Joint	<input type="radio"/> Excessive Thirst	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Tonsillitis
<input type="radio"/> Asthma	<input type="radio"/> Fainting spells/ Dizziness	<input type="radio"/> Lung Disease	<input type="radio"/> Tuberculosis
<input type="radio"/> Blood Disease	<input type="radio"/> Frequent Headaches	<input type="radio"/> Mitral Valve Prolapse	<input type="radio"/> Tumors or Growths
<input type="radio"/> Blood Transfusion	<input type="radio"/> Genital Herpes	<input type="radio"/> Pain in Jaw Joints	<input type="radio"/> Ulcers
<input type="radio"/> Breathing Problem	<input type="radio"/> Hay Fever	<input type="radio"/> Parathyroid Disease	<input type="radio"/> Venereal Disease
<input type="radio"/> Bruise Easily	<input type="radio"/> Heart Attack/ Failure	<input type="radio"/> Psychiatric Care	<input type="radio"/> Yellow Jaundice
<input type="radio"/> Cancer	<input type="radio"/> Heart Murmur	<input type="radio"/> Radiation Treatments	<input type="radio"/> OTHER:
<input type="radio"/> Chemotherapy	<input type="radio"/> Heart Pace Maker	<input type="radio"/> Recent Weight Loss	<input type="radio"/> I do not currently have and have not previously had any of the above conditions or any other serious condition not listed above.
<input type="radio"/> Chest Pains	<input type="radio"/> Heart Trouble/ Disease	<input type="radio"/> Renal Dialysis	
<input type="radio"/> Cold Sores/ Fever Blisters	<input type="radio"/> Hemophilia	<input type="radio"/> Rheumatic Fever	
<input type="radio"/> Congenital Heart Disorder	<input type="radio"/> Hepatitis type: _____	<input type="radio"/> Rheumatism	
<input type="radio"/> Convulsions	<input type="radio"/> Herpes	<input type="radio"/> Scarlet Fever	

Emergency Contact: Name: _____ Phone: _____

Comments: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN

DATE

PERSONAL DENTAL PROFILE

Patient: _____

Date: _____

What dental problems have you had in the past? _____

What has been your experience with dentistry in the past? _____

Why did you change from your last dental office? _____

- | | | |
|--|---------------------------|--------------------------|
| Have you ever been treated for gum disease? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do your gums bleed? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you feel you have bad breath? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you wish your teeth were whiter? | <input type="radio"/> Yes | <input type="radio"/> No |
| Are you dissatisfied with the way your teeth are shaped? | <input type="radio"/> Yes | <input type="radio"/> No |
| Are you dissatisfied with your smile? | <input type="radio"/> Yes | <input type="radio"/> No |
| Have you been told that you snore? | <input type="radio"/> Yes | <input type="radio"/> No |
| Have you been told you grind your teeth? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you play sports? | <input type="radio"/> Yes | <input type="radio"/> No |

If yes, which sports do you play? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

On a scale from 1 to 10, how would you rate your apprehension with dental visits with 10 being very nervous? _____

On a scale from 1 to 10, how important is it for you to keep your teeth for a lifetime with 10 being very important? _____

What expectations do you have for your oral health in the future and how will you achieve these goals? _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
MICHEL FAMILY DENTISTRY
Patrick M. Michel, DMD, PA

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **MICHEL FAMILY DENTISTRY** "NOTICE OF PRIVACY PRACTICES", revision date March 23, 2013.

As required by the Privacy Regulations, _____ from **MICHEL FAMILY DENTISTRY** has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **MICHEL FAMILY DENTISTRY** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- I wish to file a "Request for Restriction" of my Protected Health Information.
- I wish to file a "Request for Alternative Communications" of my Protected Health Information.

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".

I have read "NOTICE OF PRIVACY PRACTICES" and understand my rights contained in the notice. By way of my signature, I provide MICHEL FAMILY DENTISTRY with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (Printed)

Patient's Signature

Date

Authorized Facility Signature or Parent/Guardian if Minor

Date

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

The following effort was made to obtain receipt: (Describe)

PATIENT'S AUTHORIZATION REQUEST FORM

You may give Dr. Patrick Michel written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below:

PLEASE PRINT:

Patient's Name: _____ Middle Initial: _____ Last Name: _____

Patient's Date of Birth: _____ / _____ / _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

At my request, I authorize Patrick M. Michel, DMD, PA to disclose my Protected Health Information to:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I, _____, authorize Patrick M. Michel, DMD, PA to disclose the following PHI to the person/ entity listed above. Check all that apply:

- Patient Information
- Payment Information
- Claims Information
- All services from a specific health care provider
- Benefit Information
- Explanation of Insurance Benefits
- All Information Requested

Patient's
Signature: _____ Date: _____

(If the patient is a minor, the guardian needs to sign.)

Patrick M. Michel, DMD, PA
3314 Healy Drive, Suite 101
Winston-Salem, NC 27103

FINANCIAL POLICY

Thank you for selecting our office as your dental provider. The following is a statement of our financial policy which we ask that you **read, understand and sign prior to any treatment**. We are committed to the best possible dental care and we are happy to discuss our professional fees with you at any time during our normal office hours. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our providing you with financial policy, or your responsibility. Payment is requested at each appointment as service is rendered and can be made by **Cash, Check, Master Card, Visa, American Express, Discover, or Care Credit**. Please be aware that if you are a parent bringing a child to our office you are legally responsible for payments on all charges. We cannot send statements to other addresses.

DENTAL INSURANCE INFORMATION

As a courtesy to you, our patients, we will file your dental insurance claim for you. We also, as a courtesy to you, will accept assignment of benefits. We will only accept this assignment of benefits after you are a patient of record with us. Once we have verified your insurance benefits, we will begin filing your claims for you. For appointments such as cleanings, we will bill the insurance company. If you need to return for restorative, we will collect your yearly deductible at the time the service is rendered. If you are in need of a crown, bridge, or denture, we ask that you pay a portion of what you will be responsible for at the initial appointment, and that the remaining portion be paid at the delivery appointment. Please keep in mind we estimate what we think the insurance will pay. Once the insurance company reimburses us, you will be billed for any remaining balance.

You, the patient, are responsible for your entire account balance. If, for some reason, your insurance company becomes unduly difficult to deal with, we ask that you proceed with whatever measures you deem appropriate to collect on your claim. Please provide us with the following information in order to file your claim:

Patient's Name: _____
Employee Name: _____
Employee Date of Birth: _____
Employee Social Security Number: _____
Company Where Employed: _____
Insurance Company Name & Number: _____

I authorize the release of any information concerning mine or my child's dental care, advice, and treatment provided for the purposes of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me and I understand that I am financially responsible for payments in full of all accounts.

Signature of patient, parent, or guardian _____ Date: _____
