## NEW PATIENT INFORMATION

Date: _____

Patient Name: _____

Date of Birth: _____ Social Security: _____-_____-_____

Address, City, State, Zip: _____

Phone Numbers: Home: _____ Cell: _____
Work: _____ Other: _____

E-mail address: _____

How would you prefer to receive appointment reminders? Text_____ Email_____ Call____

Place of Employment: _____ Job Title: _____

How did you hear about our office? Google ____ FB ____ Insurance ____ Referral ____

If referred, who may we thank? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

## FINANCIAL INFORMATION

Name of Responsible Party (Insured): _____

Relationship to patient: _____ Phone: _____

Address, City, State, Zip: _____

Date of Birth: _____ Social Security: _____-_____-_____

Insurance Carrier: _____

Group/Policy Number: _____ Member Number: _____

Employer: _____ Employer Phone: _____

I authorize payment of dental benefits, otherwise payable to me, directly to the dentist or dental entity.

Signed: _____ Date: _____

# MEDICAL HISTORY INFORMATION

Please circle any conditions that apply, either currently or chronically:

| | | | |
|---|---|---|---|
| Allergies | Cosmetic Surgery | Hepatitis (type?) | Pregnancy (current) |
| Anemia | Cough (persistent) | Herpes | Radiation Treatment |
| Angina Pectoris | Diabetes (type 1 or 2) | High Blood Pressure | Recent Weight Loss |
| Anxiety | Emphysema | Hypoglycemia | Respiratory Problems |
| Arthritis | Epilepsy/Seizures | Jaundice | Rheumatic Fever |
| Artificial Joints | Excessive Bleeding | Joint Replacement | STDs |
| Asthma | Fainting/Dizziness | Kidney Disease | Scarlet Fever |
| Back Trouble | Fever Blisters | Kidney Disorders | Shortness of Breath |
| Blood Transfusions | Frequent fatigue | Leukemia | Sinusitis |
| Bruise Easily | Glaucoma | Liver Disease | Skin Eruptions/Rash |
| Bulimia/Anorexia | HIV Positive/AIDS | Lung Infections | Stroke |
| Cancer/Tumors | Headaches | Meningitis | Swelling of Feet |
| Chemical Dependency | Heart Attack | Migraines | Thyroid Disorders |
| Chemotherapy | Heart Disease | Mitral Valve Prolapse | Tuberculosis |
| Chest Pains | Heart Murmur | Nose Bleeds | Ulcers |
| Cold Sores | Heart Surgery | Pacemaker | |

Please elaborate on any selected conditions, i.e. diagnosis date, medications prescribed, etc.:

_____

_____

Please identify any conditions not specified above: _____

Please circle the following items if you suffer allergic reaction:

| | | | |
|---|---|---|---|
| Aspirin | Fluoride | Nickel | Tetracycline |
| Codeine | Latex | Penicillin | Valium |
| Erythromycin | Mercury | Sulfa Drugs | Local anesthetics |

Please identify any medicinal allergies not listed: _____

_____

Physician: _____ Address: _____ Phone: _____

Do you need to pre-medicate before dental appointments?_____If so, why?_____

Please identify how often you use the following:

| | Daily | Weekly | Monthly |
|---|---|---|---|
| Alcoholic Beverages | | | |
| Breath mints/Gum | | | |
| Soft Drinks | | | |
| Coffee/Tea | | | |
| Recreational Drugs | | | |
| Chewing Tobacco | | | |
| Cigarettes/Cigars/Pipe | | | |

## DENTAL HISTORY INFORMATION

What is the reason for your visit today? _____

When was your last dental visit? _____

Who was your previous dentist? _____

Why did you leave your previous dentist? _____

Have you had orthodontic treatment? _____

With whom? _____

How often to do you brush your teeth? _____ Floss? _____

Is your toothbrush: Soft? _____ Medium? _____ Hard? _____

Do you brush your teeth: Lightly? _____ Vigorously? _____

Using a scale of 1-4 (1 being most important, 4 least important), rate the following in order of importance to you:

_____ Health of my mouth

_____ Appearance of my smile

_____ Function of my bite

_____ Cost of my treatment

Please rate the health of your mouth, 1 being the best score and 10 being the lowest: _____

Please add any details pertinent to the care of your smile, including but not limited to details of previous dental visits, reasons for previous tooth extraction, previous recommended treatments, etc.: _____

_____

_____

_____

| **Oral Health History Questionnaire:** | **Yes** | **No** |
|---|---|---|
| Are you currently experiencing any discomfort or pain with particular teeth or areas of your mouth? | | |
| Have you ever had any teeth removed due to decay, fractures, or periodontal disease? | | |
| Have you had your wisdom teeth removed? When?_____ With whom?_____ | | |
| Have you ever had any orthodontic treatments? | | |
| Do you feel pain when your teeth come into contact with:<br>- Hot temperatures (ex: soup, coffee, tea, etc.)<br>- Cold temperatures (ex: cold water, ice cream, etc.)<br>- Sweets (ex: candy, soda, etc.) | | |
| Do you have any broken fillings? | | |
| Do you have any loose teeth? | | |
| Do you have sensitivity when biting or chewing? | | |
| Do you grind and/or clench your jaw frequently? | | |
| Do you experience any pain when opening or closing your jaw? | | |
| Do you experience any popping or clicking when opening or closing your jaw? If yes, Does that occur on the **right** side or **left** side or **both** (*please circle*)? | | |
| Do you feel like your teeth are shifting? | | |
| Have you noticed a change in your bite? | | |
| Do you wear any dental appliances? | | |
| Have you been told that you snore? | | |
| Do you suffer from sleep apnea? | | |
| Do you use a CPAP machine? | | |
| Do you have bad breath or a bad taste in your mouth? | | |
| Is there a history of gum disease in your family? | | |
| Do your parents have all of their teeth? | | |
| Have you been told by a dentist that you have gum disease? | | |
| Have you ever had any blisters, sores, or growths in your mouth or on your lips? | | |
| Do your gums feel irritated or swollen? | | |
| Do your gums bleed when flossing, chewing, or brushing? | | |
| Do you currently or have you previously smoked cigarettes or chewed tobacco? | | |
| Do you frequently experience headaches? | | |
| Have you ever had any head, neck, or jaw injuries? | | |
| Have you ever had local anesthetic for dental treatment? | | |
| Have you ever had professional instruction on oral hygiene? | | |

## SMILE SURVEY

Please take a moment to tell us about your smile so we may better serve your individual needs.

Check the items applicable to you:

| | |
|---|---|
| | I wish my teeth were straighter. |
| | I wish I had a broader smile. |
| | I think some of my teeth are too small. |
| | I think some of my teeth are too big. |
| | I wish my teeth were whiter. |
| | I think my gums show too much when I smile. |
| | I think my smile shows too much space between some of my teeth. |
| | I sometimes hesitate to smile because of the appearance of my teeth. |
| | Concern for fees prevents me from enhancing my smile. |
| | I feel I could do a better job protecting the health of my teeth and gums. |
| | I feel there are options for enhancing my smile that I am not aware of. |

Have you ever had an unfavorable dental experience? If yes, please explain:

_____

_____

_____

_____

When I see a picture of myself, the first thing I notice about my smile is:

_____

_____

_____

If I could change anything about my smile, I would change:

_____

_____

_____

Some things I consider appealing about other people's smiles are:

_____

_____

# OFFICE POLICIES AND PROCEDURES

## Consent for Services, Payment, and Cancellation Policy

- As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

- This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, rendered services are overall the responsibility of the patient and all copayment estimates are to the best of our knowledge. Any remaining costs following insurance payments are the responsibility of the patient.

- In consideration for the professional services rendered by Dr. Wisniewski, patients agree to pay half of the estimated fees for services to Dr. Wisniewski at the time of scheduling, to reserve the appointment time with the doctor, and the remaining half at the time services are rendered.

- I will be responsible for any lab fees that are incurred, as a result of my treatment, even if I do not follow through with the entire treatment process. Typically, lab fees are included in the fee for services rendered.

- We understand that circumstances may change and with that in mind, we require a minimum of **48 hour** notice when an appointment must be changed. In the event that a patient fails to give this notice, a **$100.00** fee will be assessed. Please note this fee is not covered by dental insurance.

- There will be a **$50.00** fee for any returned forms of payment. Outstanding unpaid balances older than 90 days will be sent to collections.

I understand this policy and will adhere to its contents.

Signed: _____ Date: _____

**Insurance Estimates**

In order to provide all of our patients with the best possible care, we require payment for your treatment at the time of service. As a courtesy to you, we will file your dental insurance claim for you. We will then collect only what we believe your portion for the services will be. We would like for you to understand that any quote given by a member of the ELITEdental team is only an estimated portion and may change in accordance to the payment, or lack thereof, made by your insurance provider. We will, however, do our very best to get you an accurate quote for services, but it should be understood that each insurance plan has its own unique exceptions and payment guidelines.

I understand that the team will only be giving me an **estimated** portion, and that the amount due on my account may change in accordance to the payment made by my insurance provider.

Signed: _____ Date: _____

**Authorization for Release of Dental Records and X-Rays**

I, _____, hereby authorize the office of ELITEdental to retrieve records, x-rays, and/or knowledge concerning my dental health from previous dental care providers.

Signed: _____ Date: _____

**Privacy Practices**

I acknowledge that I have received ELITEdental's "Notice of Privacy Practices". (Last page of paperwork)
Signed:_____ Date:_____

# HIPAA DISCLOSURE AUTHORIZATION FORM

Full Name _____ Date of Birth: _____

I hereby authorize **ELITEdental** to use or disclose my protected health information related to **dental treatment, history, and records** to the following individuals:

- ☐ Name _____ Relationship_____
- ☐ Name _____ Relationship_____
- ☐ Name _____ Relationship_____

**OR:**

- ☐ My health information is not to be released to anyone at this time.

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- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

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_____ _____

Date Signature of Individual or Representative

_____

Authority or Relationship to Individual, if Representative

EXPIRATION DATE:
This authorization will expire on _____. If no date is given, this will expire 9 months after death of the individual.

# ELITEdental NOTICE OF PRIVACY PRACTICES Form 7.20

**This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.**

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

**Your Rights Under The Privacy Rule**

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

**You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices** - We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

**You have the right to authorize other use and disclosure** - This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to request an alternative means of confidential communication** – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and obtain a copy your PHI*** - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

**You have the right to request a restriction of your PHI*** - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

**You have the right to request an amendment to your protected health information*** - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

**You have the right to request a disclosure accountability*** - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

**You have the right to receive a privacy breach notice** - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at the bottom of the following page.

**How We May Use or Disclose Protected Health Information**

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

**Treatment** - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

**Payment** - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

**Healthcare Operations** - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

**Special Notices** - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

**Health Information Organization** - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

**To Others Involved in Your Healthcare** - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

**Other Permitted and Required Uses and Disclosures** - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

**Privacy Complaints**

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:

400 136th Avenue, Suite 300, Holland, MI 49424 616.396.9583 Effective Date: 10/1/18 Publication Date: 10/1/18