Kalamazoo Family & Cosmetic Dentistry
STEVEN RAY, D.M.D.

Name: ____
Last First MI Preferred Name

Address: _______________________ City:__________________ State:________ Zip:_________________

Sex: M F Age: __________ DOB: ________________ SSN: ________________________________

Cell Phone: ____________________________ Home Phone: ________________________________

Email: ________________________________ Work Phone: ________________________________

Employer: _____________________________ Occupation: ________________________________

Marital Status: Single Married Divorced Widowed Separated Domestic Partner

Do you prefer to be contacted by our office via email or phone? (Please circle preference)

How did you hear about us? ____

Insurance – Primary

Subscriber Name: ________________ Relationship to patient: ____________Subscriber DOB: __________

Subscriber SSN/ID: ___________________ Subscriber Employer: _________________________________

Insurance Company Name: ___________________________Group # _____________________________

Insurance – Secondary

Subscriber Name: ________________ Relationship to patient: _____________Subscriber DOB: _________

Subscriber SSN/ID: ___________________ Subscriber Employer: _________________________________

Insurance Company Name: ___________________________Group # _____________________________

Assignment and Release
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Kalamazoo Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorized the use of this signature on all insurance submissions.

Responsible Party Signature: ____

Relationship: _______________________________ Date: ______________________________________

Name: ______________________________

Date: ______________________________

Medical History

Do you have a personal physician? Yes No
Physician's Name:
____
Physician's Phone:
____
Date of last visit:
____

Your current physical health is: Good Fair Poor
Are you currently under the care of a physician? Yes No
Please explain:
____
Do you use tobacco in any form? Yes No
Have you had any metal rods, pins or implants placed? Yes No
Are you taking any medications? Yes No
Please list each one: ______________________________

Have you ever had any surgical procedures? Yes No
Please list each one: ______________________________

Please circle any condition(s) you have, have had, or have been treated for:

Abnormal Bleeding
Alcohol Abuse
Allergies
Anemia
Angina Pectoris
Arthritis
Artificial Heart Valve
Asthma
Blood Transfusion
Cancer
Chemotherapy
Colitis
Congenital Heart Defect
Diabetes
Difficulty Breathing
Drug Abuse
Emphysema
Epilepsy
Facial Surgery
Fainting Spells
Fever Blisters/ Cold Sores
Frequent Headaches
Glaucoma
HIV / AIDS
Heart Attack
Heart Murmer
Heart Surgery
Hemophilia
Hepatitis A
Hepatitis B
Hepatitis C
High Blood Pressure
Joint Replacement
Kidney Problems
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Pace Maker
Psychiatric Conditions
Radiation Therapy
Rheumatic Fever
Seizures
Sexually Transmitted Disease
Shingles
Sickle Cell Disease
Sinus Problems
Stroke
Thyroid Problems
Tuberculosis
Ulcers

Allergies?

Aspirin	Latex
Codeine	Metals
Dental Anesthetics	Penicillin
Erythromycin	Tetracycline
Other:	

If Female, Please Answer:

Are you taking any birth control medications? Yes No

Are you or could you be pregnant? Yes No

If yes, how many weeks? ____________

Are you nursing? Yes No

Name: ___________________________________

Date: ____________________________________

Dental History

How may we help you today? ____

Are you in any pain? If so, explain. ____

Do you require antibiotics before dental treatment? *Circle one* Yes No
Have you ever had gum treatment? Yes No
Do you know or have you had any pain/discomfort in your jaw joint (TMJ)? Yes No
Do you clench or grind your teeth? Yes No
Do you have headaches, earaches, or neck pain? Yes No
Do you like your smile? Yes No
Are you happy with the color of your teeth? Yes No
Do you like the shape / look of your teeth? Yes No
Is there anything you would like to change about your smile? If so, explain: ___________________________

____

Do your gums bleed, feel tender or irritated? Yes No
How many times do you floss per week? ___________
Do you have any loose or shifting teeth? Yes No
Do you experience any pain when you chew? Yes No
Are your teeth sensitive to Heat? Cold? Sweets? Pressure? Anything else? ___________________________
Have you ever had a serious / difficult time with any dental treatment? Yes No
Have you ever had an unfavorable dental experience? Yes No
Are you apprehensive about dental treatment? Yes No
Do you want dental anesthetic used? Yes No
Have you ever had problems with dental anesthetic? Yes No

When was your last dental exam? ____________________ Cleaning? ________________________

Why did you leave your previous dentist? ____

Is there anything we can do to make your dental visit easier? ____

____

Here at Kalamazoo Family & Cosmetic Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Veneers	Crown / Bridge
Invisalign	Smile Makeover	Dental Implants
Six Month Smiles (braces)	Bonding	Night guard/ Bite Splint
Sealants	Partial/ Dentures	Athletic Mouthguard

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

For more information about our privacy practices, or to request a copy of our Notice please contact us using the information listed on this website.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed on this website. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).

Kalamazoo Family & Cosmetic Dentistry
1850 Whites Rd., Kalamazoo, MI 49008 (269) 342-5321
Steven Ray, D.M.D.
Verle Wiita, D.D.S.

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Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

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Verle Wiita, D.D.S.

Financial Agreement Form

Our practice is passionate about your dental health and takes pride in providing you with the best care possible. Our team will take time to discuss our professional fees and financial options with you that will allow you to make informed decisions regarding your dental treatment and select a financial arrangement that is affordable for you. Your clear understanding of our Financial Arrangement Form is very important to our professional dental relationship. If you have any questions or concerns, please do not hesitate to ask.

Payment is due and payable at the time of services are rendered. For your convenience, we accept cash, personal checks, Visa, Master Card, and Discover Card.

Payment Plans/ Financial Arrangements will be extended to patients having comprehensive dental treatment of $300 or more with no insurance coverage.

- Major Treatment (no insurance coverage)— Payment of 50% of the total treatment must be made at the first appointment with the remainder being paid at the time of completion.
- 5% Courtesy Discount- You can take advantage of our courtesy discount if you decide to pay your full treatment in advance by either cash, check, or credit card.
- Automatic Monthly Payment by Credit Card- (3 months maximum). Patients can use their credit care of choice to make monthly payments for their treatment. We require signed authorizations from you allowing our practice to charge your card monthly for completed treatment.
- No Interest Financing- We now offer a financing option through Care Credit. This option offers no interest payment plans with affordable low monthly payments, and is easy to apply in office, online, or by phone. Please see a staff member for information.
- A 1.5% account service change will be assessed each billing period on all balances 90 days or more past due.

Dental Insurance — If you have dental insurance to help you with your payment please submit a photocopy of your insurance card. We cannot bill your insurance until we receive your insurance information. As a courtesy, we will process your insurance claim. However, we do ask that your estimated payment be paid on the day of your visit (your deductible and/or co-payment). Please understand your insurance policy is a contract between you and your insurance company. Any excess monies collected by our practice will be refunded to you once we receive the insurance check, or in case of an underpayment by your insurance company, the remaining balance will be due within 30 days.

Broken Appointment —In our practice an appointment made by you is confirmation that you are committed to your treatment as our team of Doctors and Hygienists are committed to taking care of your treatment needs. We realize emergencies do arise, but appointments cancelled or rescheduled with less than 24 hours notice will necessitate us to charge a $40 fee per occurrence. While we will do our best to accommodate you, please note that if you arrive 10 minutes or more after your scheduled appointment time, we will need to reschedule your appointment.

I hereby acknowledge receipt of the above payment options.

Print Name: ____

Signature: ____ Date: _________________________

Patient 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 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.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review 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; a licensure investigation; or a child abuse/neglect investigation.

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

Patient Acknowledgement & Consent

Please sign this form below to acknowledge that you have today received a copy of our notice of privacy practices, and that you consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I acknowledge that I have, today, received a copy of the Notice of Privacy Practices; I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand the such disclosures may not be of the type listed above.

______________________________ ______________________________
Patient Signature Patient Name (please print)

____
Date

For Office Use Only:

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement:
____

An emergency situation prevented the patient from signing the Acknowledgement.

______________________________ ______________________________
Office Personnel (signature) Office Personnel (print name)

Date: ______________________________