Family Smiles Dental Care

Joseph Matievich, D.D.S., PPLC

PATIENT REGISTRATION FORM

Patient Name _____ Birth Date _____

Address _____ City/State/zip _____

Home Phone _____ Cell Phone _____ SS# _____

Email Address _____

Sex: Male_____ Female_____ Single_____ Married_____ Widowed_____ Separated_____ Divorced_____

Full Time Student Yes or No_____ Name & Address of College _____

Employer _____ Work Phone _____

Spouse's Name _____ Cell Phone _____ Work Phone _____

Whom may we thank for referring you to our office? _____

In case of emergency, contact (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

I understand that payment is expected upon services rendered. Additionally, if insurance is utilized, I am financially responsible for all charges whether or not paid by insurance.

Patient Signature (or Guardian): _____ Date _____

INSURANCE INFORMATION

Primary Insurance Co._____ Group # _____ Contract #_____

Insurance Co. Phone #_____ Employer _____

Subscribers Name _____ Birth Date _____ SS# _____

Relationship to Patient_____ Is the patient covered by additional insurance?_____

Secondary Insurance Co._____ Group # _____ Contract # _____

Insurance Co. Phone # _____ Employer _____

Subscribers name _____ Birth Date _____ SS# _____

Relationship to Patient _____

Assignment and Release: I have insurance coverage per above and assign directly to Dr. Matievich all information benefits otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Date _____

Are you taking any medications? _____ Yes _____ No

MEDICATIONS	AILMENT OR DISEASE	DATE OF ONSET
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

To my knowledge, the information provided is correct and complete. If the patient is a minor, permission is hereby given for dental treatment as deemed necessary to be performed in our office or until written notice is given discontinuing this permission. (If insurance coverage is applicable, insurance plans are entirely the responsibility of the insured and billing of insurance is a courtesy to our patients. Patients will be financially responsible for all dental treatment rendered. I hereby authorize the dentist to release any information to the insurance company relating to my claim.

Signature _____ Date _____

Signed _____ Date _____ Signed _____ Date _____

(Health History reviewed for office use only.)

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENTS SIGNATURE	BP	REVIEWED BY
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____

Additional Notes

Patient Health History

Patient's Name _____

Welcome to our office, please provide us with the following information:

Main reason for your visit today _____

Previous dentist _____ City _____ Phone # _____

Date of last x-rays _____

Current physician's name _____ Date of last medical visit _____

Do you have or do you use any of the following?

_____ Teeth sensitive to cold/hot sweets/pressure
_____ Bleeding gums
How long? _____
_____ Food impaction
_____ Clenching & grinding
_____ Burning of tongue
_____ Swelling or lumps in mouth
_____ Blisters on lips or mouth
_____ Unusual sounds in ears while eating?
_____ Bad breath
_____ Unpleasant taste
_____ Unfavorable dental experience
_____ Extraction complication
_____ Periodontal (gum) treatment
_____ Mouth breathing
_____ Oral habits (nail biting, etc.)
_____ Smoking - how many a day_____
S, M, H -Texture of toothbrush
_____ Frequency of brushing
_____ Dental floss
_____ Interdental stimulators
_____ Water jet device
_____ Disclosing tablets/solution
_____ On the market whiteners

Do you have or have you had any of the following?

_____ Allergies to drugs
List: _____
_____
_____
_____ Allergies to anesthetics or any abnormal reactions
_____ Alcohol/drug treatment
_____ Anemia or blood problems
_____ Angina
_____ Are you pregnant?
What month? _____
_____ Are you taking birth control pills?
_____ Arthritis
_____ Asthma _____ Inhaler?
_____ Blood transfusions
_____ Cancer or tumors
_____ Communicable diseases
List: _____
_____ Diabetes
_____ Epliepsy/convulsions/seizures
_____ Excessive bleeding from cuts/extractions
_____ Eye disorders/Glaucoma
_____ Hay fever/general allergies
_____ Heart attack
_____ Heart murmur/Mitral Valve Prolapse
Pre Med? _____
What Antibiotic? _____
Cardiologist? _____
Doctor's Phone # _____
_____ Hemophilia
_____ Hepatitis __A __B __C __D
_____ High blood pressure
_____ HIV/AIDS
_____ Joint replacement or implants
Date of implant? _____
Pre Med? _____
_____ Kidney problems
_____ Liver problems
_____ Lung disease
_____ Malignancies
_____ Neurological problems
_____ Pacemaker
_____ Psychiatric care/emotional
_____ Radiation treatments
_____ Rheumatic fever
_____ Stroke
_____ Thyroid
_____ Tonsillitis/sinus problems
_____ Tuberculosis
_____ Ulcer or colitis

Pharmacy Name? _____ Pharmacy Phone # _____

Do you have any disease, condition or problem not listed? _____

Family Smiles Dental Care
Joseph Matievich, DDS, PLLC
2064 W. Auburn Road
(248)853-2222

We welcome you as a patient and appreciate the opportunity to provide you with the best care that is available.

Thank you for choosing us as your dental care provider. Our purpose is to enable our patients to achieve excellence in dental health. We will make every effort to provide gentle dentistry in a caring and pleasant atmosphere.

APPOINTMENTS:
Unless notified at least 48 hours in advance, our policy is to charge for missed appointments of $50. Cancellations that are left on the answering machine must also be 48 hours in advance. This courtesy allows us to appoint patients who are waiting for appointments.

PAYMENT METHODS:
Full payment is expected at the time services are rendered. We accept cash, checks, Visa, Master Card, Discover and American Express. Also, there is an interest free payment plan if you qualify. A $25 fee will be assessed for any returned checks.

MINOR PATIENTS:
A parent or guardian must accompany minor patients. Unaccompanied minors may be denied treatment unless prior arrangements have been made.

INSURANCE:
We accept assignment of insurance benefits providing all paperwork and necessary information is completed. However, we do require that the deductibles and co-payments be paid at the time of the service. Your insurance policy is a contract between you, your employer, and the insurance company. ***We do everything possible to ensure coverage as estimated by your insurance but in the event your insurance company rejects a service rendered or does not pay what is estimated, you are responsible for any fees that your insurance company excludes.*** *We allow 45 days grace period for all insurance claim payments to arrive. If no payments have been made by then, the balance is transferred to you. All balances are due upon receipt and are subject to a one time billing charge of $15.00 if the account becomes 60 days overdue.*

I have read the office policy, understand and agree with it.

Signature: _____ *Date:* _____

Thank you,

Joseph Matievich, DDS, PLLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Family Smiles Dental Care
Joseph Matievich, DDS, PLLC
2064 W. Auburn Rd.
Rochester Hills, MI 48309

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assurance assessments or routine appointment reminders.

I acknowledge that I have received or reviewed your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason:

_____

_____

Date: _____ Initials: _____