GREAT LAKES PERIODONTICS
Laser Surgery & Dental Implants
James C. Papp, DMD | Rachel S. Sinacola, DDS, MS

PATIENT HEALTH HISTORY

Patient Name_____ Patient Age_____
DDS Name_____ Are you being treated by a doctor at this time? _____
What condition_____
Please list any medications_____
_____
Please list any allergies or sensitivities_____

Have you had any hospitalizations or surgical procedures in the last 2 years?_____

Do you smoke_____ If so, how much_____ Last dental cleaning_____ Frequency of cleanings_____

Do you clench/grind your teeth_____ Do you wear a bite splint_____ How often_____

Previous orthodontics_____ Age_____ Have you had any periodontal/gum treatment in the past_____

Do you now or have you had any of the following conditions? Please check all that apply:

___ HIV/Aids
___ Anemia
___ Arthritis
___ Artificial Joints
___ Asthma
___ Blood Disease
___ Cancer
___ Diabetes___ last A1C___ Family history
___ Dizziness/Fainting
___ Epilepsy/Seizures
___ Excessive Bleeding
___ Glaucoma
___ Hay Fever
___ Heart Disease
___ Heart Murmur
___ Hepatitis
___ High Blood Pressure ___ is it stable
___ Jaundice
___ Kidney Disease
___ Liver Disease
___ Mental Disorders
___ Nervous Disorders
___ Pacemaker ___ Approx year placed
___ Radiation Treatment
___ Respiratory Problems
___ Rheumatic Fever
___ Sinus Problems
___ Stomach Problems
___ Stroke
___ Tuberculosis
___ Ulcers
___ Cold Sores ___ Frequency
___ Taken Bisphophonates (i.e.: Fosamax)
___ Jaw Joint pain/click

Do you have Dental Anxieties: 1 2 3 4 5 6 7 8 9 10
(1=none 5=normal apprehension 10=IV sedation required)

Have you had any trouble with previous dental treatment?_____
*Do you have any health problems that need further clarification?_____

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 healthy, I will inform the doctors at the next appointment without fail.

Signature of Patient or Guardian_____

Date_____

GREAT LAKES PERIODONTICS
Laser Surgery & Dental Implants
James C. Papp, DMD | Rachel S. Sinacola, DDS, MS

PATIENT HEALTH HISTORY

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 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 HIPPA's requirements, we are giving you a copy of our Privacy Practices. This notice of Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain written consent prior to disclosing any of your informations except for our disclosures in connection with: a defence to a claim challenging our professional competence; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation or 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 your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

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

Patient Signature_____

Patient Name (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)_____
Date_____

Patient Acknowledgement

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment.

I understand that such disclosures may not be of the type listed above.

Patient Signature_____

Patient name (Print)_____ Date_____

GREAT LAKES PERIODONTICS
Laser Surgery & Dental Implants
James C. Papp, DMD | Rachel S. Sinacola, DDS, MS

PATIENT HEALTH HISTORY

Patient Information

Patient Name_____

Date of Birth_____ Email_____

Home phone_____ Work phone_____ Cell phone_____

Social Security # ___-___-___ Address_____

City_____ State_____ Zip Code_____

Emergency Contact_____Phone_____

Primary Dental Insurance

Person who carries the insurance_____ Social Security # ___-___-___
Dental Insurance Company_____ ID #_____
Employer_____
Group #_____ Date of Birth_____

Secondary Dental Insurance
Person who carries the insurance_____ Social Security # ___-___-___
Dental Insurance Company_____ ID #_____
Employer_____
Group #_____ Date of Birth_____

Consent For Services and Release of Benefits

If you have dental insurance, we will file the claims for you, as a complimentary service. We do ask that the correct insurance information be provided at the time of your appointment in order for us to timely file the claim and collected payment. If this information changes, it is the patient's responsibility to update our office at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee that your insurance company will reimburse us/you according to these estimates. It is possible that we could preauthorize any treatment to verify plan coverage and benefits. Please note any difference in payment from your insurance company and your account balance is your responsibility. We emphasize that as dental care providers, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient and/or account holder. Payment for services (copay/coinsurance) is due at the time the services are provided. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) to Dr. James C. Papp for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

I/We understand the above paragraph regarding dental insurance, and have had the opportunity to have any questions answered to the best of my/our ability.

Signature of responsible party_____

Date_____