Thank you for choosing Marnie Grant D.D.S. Caring Family Dentistry.

If you are a new patient, please fill out the attached forms in advance of your appointment to assist the staff in making sure that we have all the information necessary to provide you with quality care and treatment. Simply **print out** the forms, fill in the information requested, and bring the completed form with you to your appointment.

Instructions to Download and Print Forms:

- Download the Patient Forms PDF to a desired location.

  CAUTION: Do not fill these forms out via your web browser as they will contain medical/health and personal information.

- Open the downloaded PDF in Adobe® Acrobat Reader.
- Enter your information electronically until the forms are complete and then print the forms. Or,
- Print the forms and then complete the forms.

If you have any questions or need assistance, please call our team at 734-482-8671.

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

If this appointment is for YOU start here -

1.

Date_____ / _____ / _____

Last Name_____First_____M.I._____

Prefers to be called by_____

Address _____

City _____State_____Zip _____

Home Phone No. _____Fax _____

Cell_____Email _____

Birthdate_____Age_____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security No._____

If this appointment is for YOUR CHILD start here -

Date _____ / _____ / _____

Last Name_____First_____M.I._____

Address _____

City _____State_____Zip _____

Home Phone No. _____Fax _____

Birthdate_____Age_____ ☐ Male ☐ Female

School_____Grade _____

Social Security No._____

2.

DENTAL INSURANCE

Primary Carrier

Insurance Company_____

Group No. _____

Employer Name _____

Insured's Name _____

Date of Birth _____

Relationship to Patient _____

Insured's I.D. No. _____

Insured's Social Security No. _____

Secondary Carrier

Insurance Company_____

Group No. _____

Employer Name _____

Insured's Name _____

Date of Birth _____

Relationship to Patient _____

Insured's I.D. No. _____

Insured's Social Security No._____

CONTINUES ON BACK

3.

GETTING TO KNOW YOU

Is another member of your family or relative a patient at our office?

Name _____

Relationship _____

You were referred to us by

Name _____

Person to Contact for Emergency

Name _____

Cell No. _____

Home No. _____

Address _____

City _____ State _____ Zip _____

4.

ACCOUNT INFORMATION

Person Financially Responsible for Account

Name _____

Relationship to Patient _____

Social Security No. _____

Address _____

City _____ State _____ Zip _____

Phone No. _____

YOU

Name _____

Occupation _____

Employers' Name _____

Address _____ City _____

Phone No. _____ Fax No. _____

YOUR SPOUSE

Name _____

Occupation _____

Employers' Name _____

Address _____ City _____

Phone No. _____ Fax No. _____

Patient Signature: _____ Date: _____ / _____ / _____

DENTAL HISTORY

Name _____ Nickname _____ Age _____

Referred by_____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist_____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam _____ / _____ / _____ Date of most recent x-rays _____ / _____ / _____

Date of most recent treatment (other than a cleaning) _____ / _____ / _____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment?	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury of facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid of have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐

CONTINUES ON BACK

BITE AND JAW JOINT (CONT.)

29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore? ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ☐ ☐
32. Do you wear or have you ever worn a bite appliance? ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? ☐ ☐
34. Have you ever whitened (bleached) your teeth? ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ☐ ☐
36. Have you been disappointed with the appearance of previous dental work?

Patient's Signature_____ Date _____

Doctor's Signature_____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of you general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury	☐	☐
2. an allergic or bad reaction to any of the following: aspirin, ibuprofen, acetaminophen, codeine; penicillin; erythromycin; tetracycline; sulfa; local anesthetic; fluoride; metals (nickel, gold, silver, _____); latex; nuts _____; fruit _____; other _____	☐	☐
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. pacemaker or implantable defibrillator	☐	☐
7. orthopedic implant (joint replacement)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10. a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (INR>3.5)	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis	☐	☐
14. tuberculosis, measles, chicken pox	☐	☐
15. asthma	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c+_____)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia)	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27. arthritis	☐	☐
28. autoimmune disease (i.e.rheumatoid arthritis, lupus, scieroderma)	☐	☐
29. glaucoma	☐	☐
30. contact lenses	☐	☐
31. head or neck injuries	☐	☐
32. epilepsy, convulsions (seizures)	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34. viral infections and cold sores	☐	☐
35. any lumps or swelling in the mouth	☐	☐
36. hives, skin rash, hay fever	☐	☐
37. STI/STD/HPV	☐	☐
38. hepatitis (type ____)	☐	☐
39. HIV/AIDS	☐	☐
40. tumor, abnormal growth	☐	☐
41. radiation therapy	☐	☐
42. chemotherapy, immunosuppressive medication	☐	☐
43. emotional difficulties	☐	☐
44. psychiatric treatment	☐	☐
45. antidepressant medication	☐	☐
46. alcohol/recreational drug use	☐	☐
ARE YOU:		
47. presently being treated for any other illness	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	☐	☐
49. taking medication for weight management	☐	☐
50. taking dietary supplements	☐	☐
51. often exhausted or fatigued	☐	☐
52. experiencing frequent headaches	☐	☐
53. a smoker, smoked previously or use smokeless tobacco	☐	☐
54. considered a touchy/sensitive person	☐	☐
55. often unhappy or depressed	☐	☐
56. taking birth control pills	☐	☐
57. currently pregnant	☐	☐
58. diagnosed with a prostate disorder	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's signature_____Date _____

Doctor's signature_____Date _____

ASA _____ (1-6)

MEDICAL INFORMATION RELEASE FORM

Name:_____ Date of Birth: _____ / _____ / _____

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse
- ☐ Child(ren)
- ☐ Other
- ☐ Information is not to be released to anyone.

Patient Signature:_____

Witness:_____ Date: _____ / _____ / _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 -1/2 % late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

6. Cell Phone: ☐ I consent to the dental practice using my cell phone number to (choose one or both) ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code)_____

Patient's Signature _____

Date _____

Witness _____

Parent/Responsible Party's Signature _____

Relationship to Patient _____

PATIENT ACKNOWLEDGMENT OF HIPPA

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 the HIPAA requirements, we have and you are welcome to 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 your treatment.

PATIENT ACKNOWLEDGMENT

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

I acknowledge that today I have received/ or been offered and declined a copy of the Notice of Privacy Practices.

_____

Patient or Parent/Guardian Signature

_____

Patient Name (Please Print)

Date _____

CANCELLATION POLICY

When you do not call to cancel an appointment 48 hours in advance, you may be preventing another patient from getting much needed treatment.

Our office sets aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation. When a patient fails to show up for an appointment, or to cancel within 48 hours of the appointment a patient care opportunity is missed.

If your appointment is in hygiene and is not canceled at least **48 hours in advance** you will be charged at **least a fifty dollar ($50) fee**. If your appointment is with the Dr. and is not canceled at least **48 hours in advance** you will be charged at **least a one hundred dollar fee ($100)**. This fee is NOT covered by your insurance company, and you will be responsible to pay the charge in full. *Calling 48 hours prior is a courtesy that allows my office staff to schedule another patient who is also in need of dental care.*

I have read and accept the responsibility on my part to pay the said cancellation fee if I do not follow the proper protocol (Notify our office 48 hours PRIOR to appointment to cancel)

_____

Signature

_____

Printed Name

Date: _____

Updated 08/2018