

**PATIENT REGISTRATION**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Soc. Sec. #: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Separated  Widowed

Spouse Name: \_\_\_\_\_

Referring Dentist: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Have you been a patient here before?  Yes  No

Do you Premedicate before any dental procedures with antibiotics?  Yes  No

If so, please explain why \_\_\_\_\_

\*\*Responsible party if no dental insurance: \_\_\_\_\_

\*\*If minor, parent's names: \_\_\_\_\_

**Primary Dental Insurance Information**

Name of Insured: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Parent  Step-Parent

Insured Soc. Sec. #: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Dental Ins. Name: \_\_\_\_\_

**Secondary Dental Insurance Information**

Name of Insured: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Parent  Step-Parent

Insured Soc. Sec. #: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Dental Ins. Name: \_\_\_\_\_

**MEDICAL HISTORY**

Patient Name: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_

Are you on a special diet?  Yes  No \_\_\_\_\_

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

Women: Are you \_\_\_\_\_  
Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following? \_\_\_\_\_  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  
 Other - Please explain: \_\_\_\_\_

Do you have, or have you had, any of the following? \_\_\_\_\_

|                           |  |                           |  |                       |  |                     |  |
|---------------------------|--|---------------------------|--|-----------------------|--|---------------------|--|
| AIDS/HIV Positive         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Intestinal Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pace Maker          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice     | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

## PATIENT CONSENT

### Clinical

- I authorize Grandville Endodontics, PC to perform all recommended treatment.
- I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.
- I authorize the use of anesthetics, sedatives and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissue, pain, itching, vomiting, paraesthesia, numbness, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

### Financial

- I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 2.5% MPR or 24% APR automatically tabulated into my account if my balance is 90 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.
- A \$50 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

### Insurance

- I authorize the Practice to release to staff, hospitals health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
- I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

**I have read this Patient Consent and agree to all terms and conditions herein.**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

# Grandville Endodontics, P. C.

## *Your Privacy Is Important to Us*

### Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Grandville Endodontics, P. C.. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

#### Please check your preferred means of communication:

- You may contact me at my home telephone number \_\_\_\_\_
- You may contact me on my mobile telephone number \_\_\_\_\_
- You may contact me on my work telephone number \_\_\_\_\_
- You may send me an email at: \_\_\_\_\_
- Other \_\_\_\_\_

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
2. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
3. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
4. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
5. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_

\* \* \*

#### For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify) \_\_\_\_\_

Staff Person Initials \_\_\_\_\_

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# NOTICE OF PRIVACY PRACTICES

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**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.**

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## **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.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## **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 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.)

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## 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. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.25 for each page, \$15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**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, for the last 6 years, 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.

**Restrictions:** 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

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 at the end of this Notice. 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.

**Contact Officer:** Dr. Brian J. Licari  
**Telephone:** 616-531-0780  
**Fax:** 616-531-4677  
**Address:** 4050 Del Mar Drive S.W. Suite A, Grandville, MI 49418

