PATIENT REGISTRATION & BILLING INFORMATION

Please verify the following information is correct

First Nickname Middle Last

Street Address Suite/PO Box

City State Zip Code

Which method should we use to contact you regarding your dental care, rate in order of preference

☐(___) - Home Phone ☐(___) - Work Phone Ext

☐ @ Email (we will never sell your email address; it is used only for our use – appointment reminders/occasional newsletter. You can always remove your email from our database)

☐(___) - Cell Phone Carrier

☐ Yes, text me my appointment confirmations, My carrier is:

☐ NO, do not send any text messages

Is it okay to leave a message? (Please check all that apply)

☐ Leave message on answering machine/voicemail ☐ Leave message with anyone

☐ Leave message with only select person(s)

☐ I prefer that no message be left

Birthdate Marital Status Sex (M/F)

Student (Y/N) Social Security # - -

Driver's Lic#

Employer Occupation

Address Business Phone number

Spouse Name Spouse Birthdate

Spouse's Employer Spouse's Occupation

Spouse's Business Address Spouse's Business Phone Number

Spouse's SSN# - - Spouse Driver's License #

Who is responsible for this account?

Name of Dental Insurance Company

Enrollee ID# Group #

Is there additional dental insurance coverage? ☐No ☐ Yes If yes, Dental Insurance Company

Whom may we thank for referring you? ☐Patient

☐Website (www.completelysmiles.com) ☐Facebook, Twitter, Google, Yahoo

☐Phonebook ☐Newspaper ☐Other

If you have preference for Provider(s), Hygienist, Location, or Days of the week, please indicate as such

- ❑ Dr. Thomas Coombs
- ❑ Dr. Colleen DeLacy
- ❑ Either Doctor (first available)

- ❑ Angi Neal, RDH
- ❑ Tricia Campbell, RDH
- ❑ Natalie Pruett, RDH
- ❑ Sarah Quertermous, RDH
- ❑ Josette Buerkle, RDH

- ❑ Lexington office
- ❑ Sandusky office
- ❑ Either location (first available)

Preferred day of the week

Preferred time of day

Please indicate if you have any of the following medical alerts

☐ Allergic to medication and/or substances

☐ Total joint replacement and or Cardiac diagnosis needing antibiotic pre-medication prior to dental care

In the event of a Medical Emergency; please leave the names of two people that we may contact on your behalf

Name Relationship to yourself Phone number

Name Relationship to yourself Phone number

Date Signature

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his /her staff responsible for any errors or omissions that I may have made in the completion of this form.

SEE REVERSE

Medical and Dental History

PATIENT NAME_____ **DATE OF BIRTH**_____

Please mark the check box indicating "yes" if you have currently or have had in the past any of the following:

Date of last physical examination: _____

Physician's Name _____

Any changes in your health within the past year? ☐ Yes ☐ No

Have you been Hospitalized during the past year for any reason? If so, please list reason and date(s)_____

Cardiovascular
- ❑ Low Blood Pressure
- ❑ High Blood pressure
- ❑ Angina (chest pain)
- ❑ Heart attack –Date_____
- ❑ Irregular heart beat
- ❑ Heart surgery–Date_____
- ❑ Heart failure
- ❑ Congenital heart lesions
- ❑ Damaged heart valve
- ❑ Replaced/repaired heart valve
- ❑ Mitral Valve Prolapse
- ❑ Heart murmur
  - o Congenital Murmur
- ❑ High cholesterol
- ❑ Heart infection
- ❑ Stroke–Date_____
- ❑ Pacemaker–Date_____
- ❑ Fainting/dizziness

Respiratory
- ❑ Asthma
- ❑ Tuberculosis–Date_____
- ❑ Emphysema/bronchitis
- ❑ Cough, persistent or bloody
- ❑ Sleep apnea
  - o CPAP machine in use
- ❑ Difficulty breathing
- ❑ Respiratory disease not listed
  - o _____

Ears/Nose/Throat/Eyes
- ❑ Glaucoma
- ❑ Impaired vision
- ❑ Impaired hearing
- ❑ Sinus trouble
- ❑ Tonsillitis

Hematological
- ❑ Anemia
- ❑ Sickle cell anemia
- ❑ Abnormal bleeding

Endocrine
- ❑ Diabetes
- ❑ Thyroid problem

Infections
- ❑ HIV positive/AIDS
- ❑ Sexually transmitted disease(s)
- ❑ Herpes

Renal
- ❑ Kidney disorder
- ❑ Dialysis

Immune
- ❑ Past use of steroids
- ❑ Delayed healing

Musculoskeletal
- ❑ Arthritis
  - o Rheumatoid Arthritis
- ❑ Artificial joint (s)
  - o Knee(s) Right &/or Left
  - o Hip(s) Right &/or Left
- ❑ Back problems
- ❑ Fibromyalgia
- ❑ Lupus
- ❑ Sjogren's Syndrome
- ❑ Osteoporosis

Neurologic
- ❑ Epilepsy/seizures
- ❑ Parkinson's Disease
- ❑ Multiple sclerosis
- ❑ Headaches
  - o Frequency_____

Skin
- ❑ Hives or skin rash
- ❑ Other skin lesions

Mental Health
- ❑ Bipolar disorder
- ❑ Depression
- ❑ Anxiety
  - o General
  - o Dental
- ❑ Eating disorders
- ❑ Sleep disorder
- ❑ Dementia
- ❑ Learning disorders

Hepatic
- ❑ Liver disease
- ❑ Jaundice
- ❑ Hepatitis: Type _____

Gastrointestinal
- ❑ Acid reflux/GERD
- ❑ Irritable bowel syndrome
- ❑ Stomach ulcer
- ❑ Weight loss, unexplained
- ❑ Special Diet?_____

Allergies
- ❑ Local anesthetic
- ❑ Antibiotics
  - o Penicillin
  - o Sulfa
  - o Cephalosporin
  - o _____
- ❑ Aspirin or ibuprofen
- ❑ Acetaminophen/Tylenol
- ❑ Barbiturates
- ❑ Iodine
- ❑ Codeine/narcotics
- ❑ Metals
- ❑ Latex
- ❑ Other:_____

Oncologic
- ❑ Tumor or growth in head/neck
- ❑ Cancer(s): List w/dates _____ _____
- ❑ Are you interested in a screening exam for HPV? Due to link with oral cancer if HPV positive (genital warts).
- ❑ Cancer treatment
  - o Chemotherapy
  - o Radiation treatment

Other
- ❑ Wearing contact lenses
- ❑ Do you consider yourself healthy?
- ❑ Do you consider your mouth healthy?
- ❑ Have you ever been told you need antibiotic premed for dental treatment?
- ❑ Tobacco use
- ❑ Alcohol use
- ❑ Chemical dependency
- ❑ Street/recreational/ illicit drug use

Women
- ❑ Currently nursing
- ❑ Currently pregnant
- ❑ Taking oral birth control

Medications

Check the box if you have ever taken in the past, or are currently taking any of the following medications.
If YES, circle all medications that applied/apply to you.

- ❑ Medications collectively referred to as "fen-phen." This includes combination of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and/or Redux (dexfenfluramine).
- ❑ Medications collectively referred to "blood thinners" or anti-clotting medications: warfarin (Coumadin), Aspirin, Dabigatran (Pradaxa), Clopidogrel (Plavix), Rivaroxaban (Xarelto), or injectable versions (Heparin, Lovenox)
    - o When was your last blood work and the INR value? _____
- ❑ Medications collectively referred to as bisphosphonates; generally used for the treatment of osteoporosis: Aredia, Zometa, Fosamax, Actonel, & Boniva
    - o Please list the time period you took any of the bisphosphonate medication(s) and why you were prescribed it._____

List all medications you are currently taking & the correlating diagnosis (include over the counter & prescribed)

_____
_____
_____
_____

Dental Information & History Please mark on "Y" for YES or "N" for NO

Do you want to keep your teeth?	❒ Y ❒ N
Do you like the appearance of your teeth?	❒ Y ❒ N
Do your teeth function well?	❒ Y ❒ N
Does food get caught often?	❒ Y ❒ N
Do your gums often bleed?	❒ Y ❒ N
Do you have loose teeth?	❒ Y ❒ N
Injury to head, neck, or jaw?	❒ Y ❒ N
Difficulty eating or swallowing?	❒ Y ❒ N
Do you have a dry mouth?	❒ Y ❒ N
Had a change in your ability to taste?	❒ Y ❒ N
Do you have bad breath?	❒ Y ❒ N

Problems of the jaw

Have you noticed? (check all that apply)

- ❑ Clicking of the jaw?
- ❑ Pain (joint, ear, side of face)?
- ❑ Difficulty opening or closing?
- ❑ Difficulty chewing?
- ❑ Popping of the jaw?

Oral Habits

Do you? (check all that apply)

- ❑ Clench or grind your teeth?
- ❑ Bite your lips or cheek frequently?
- ❑ Bite your fingernails?
- ❑ Have difficulty breathing through your nose?

Specific Dental History

Have you had? Check all that apply and date)

- ❑ Orthodontic treatment (braces)?_____
- ❑ Oral surgery? _____
- ❑ Periodontal (gum) treatment? _____
- ❑ Your bite adjusted? _____
- ❑ A bite plane/guard appliance? _____

Do you currently have:

- ❑ Dental pain?
    - o Jaw pain?
    - o Tooth pain?
    - o Swollen gums?
    - o Pain into the ear?
- ❑ Sensitivity to any or all of the following
    - o Cold?
    - o Heat?
    - o Sweets?
    - o Biting?
- ❑ Broken fillings?
- ❑ Sores/swellings in your mouth?
- ❑ Blisters on lips or mouth?
- ❑ A partial/full denture or dental implants?
- ❑ Do you supplement your diet with fluoride?
- ❑ Have you had any difficulty with dental treatment?
- ❑ Burning sensation on the tongue

Date of last dental x-rays? _____

How often do you brush your teeth?
❒seldom ❒ never ❒once daily ❒twice daily
How often do you floss?
❒seldom ❒ never ❒once daily ❒twice daily

Date of last dental treatment? _____
Date of last teeth cleaning? _____

Reason for today's dental visit?_____
_____
_____

To the best of my knowledge, the preceding information is complete and correct.

Signature_____ Date_____

FINANCIAL AGREEMENT FOR
THOMAS COOMBS, DDS and COLLEEN DELACY, DDS

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and education tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement below. In order for our practice to file your insurance claim, you must bring us a completed dental insurance form or proof of insurance.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, and Discover. Third party, extended payment financing is available upon request and approval through CareCredit.

Returned checks and balances older that 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Please don not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

Print Name of Patient or Responsible Party	Signature of Patient or Responsible Party	Date

ASSIGNMENT OF BENEFITS AGREEMENT FOR
THOMAS COOMBS, DDS AND COLLEEN DELACY, DDS

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company to make payment directly to our practice.
- We require you to pay the **estimated** copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an **estimate** of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not make payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company.
- Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

Print Name of Patient or Responsible Party	Signature of Patient or Responsible Party	Date

SANDUSKY DENTAL CARE
30 Dawson Street • P.O. Box 231
Sandusky, MI 48471-0231
(810) 648-4740

LEXINGTON DENTAL CARE
7305 Huron Avenue
Lexington, MI 48450
(810) 359-7321

Privacy Officer: Business Administrator **Effective Date: April 14, 2003**

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

(over)

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.