Health and Information Record

Patient Information

First Name	Middle Name	Last Name	Cell Phone Number
Home/Mailing Address			Date of Birth
Sex Female ☐ Male ☐	Email Address		Social Security Number

Dental Insurance

If you have coverage with more than one dental insurance, please let an Administration Team Member know.

Name of Policy Holder	Date of Birth of Policy Holder	Insurance Company
Member Number/Enrollee ID/Plan number	Group Number	Name of Employer (if insurance is through employer)
Social Security Number of Policy Holder	Policy Holder's Relationship to Patient	Phone Number for Providers on Insurance Card

Primary Care Information

Name of Patient's Primary Care Provider	Primary Care Provider's Phone Number
Are you currently being treated for any illnesses/disorders? (short term, e.g. strep throat, a cold, etc. **OR** chronic, e.g. diabetes, neurodivergence, etc.)	

Allergy Information

Please mark if you have an allergy or if you have every had a reaction to any of the following:

Latex Yes ☐ No ☐	Local anesthetics Yes ☐ No ☐	Penicillin **OR** any antibiotic Yes ☐ No ☐	Codeine **OR** any narcotic Yes ☐ No ☐	If you marked yes or have other allergies, please give us details.
Sulfa drugs Yes ☐ No ☐	Aspirin Yes ☐ No ☐	Metals Yes ☐ No ☐	Food **OR** seasonal allergies Yes ☐ No ☐	

Dental Health Information

Times per day I brush: _____	Times per day I floss: _____	Bleed when flossing Yes ☐ No ☐	Difficulty chewing Yes ☐ No ☐	Head/Neck/Jaw injuries Yes ☐ No ☐	Sores/lumps in mouth Yes ☐ No ☐
Jaw/TMJ pain Yes ☐ No ☐	Clench/grind teeth Yes ☐ No ☐	Bite lips/cheeks Yes ☐ No ☐	Difficulty opening/closing Yes ☐ No ☐	Hot/Cold sensitive Yes ☐ No ☐	Sweet/Sour sensitive Yes ☐ No ☐
Has your primary care provider or dentist ever recommended you take antibiotics prior to dental treatment? Yes ☐ No ☐			Do you use tobacco? (Pipe, cigarettes, vape, etc.) Yes ☐ No ☐	Have you had any problems with dental work in the past? Yes ☐ No ☐	

Medication and Health Information

Do you take birth control? Yes ☐ No ☐	Do you take drugs not prescribed by your doctor? Yes ☐ No ☐	Do you take aspirin/a blood thinner? Yes ☐ No ☐	Do you take a bisphosphonate? Yes ☐ No ☐
Since 2001, have you taken an antiresorptive agent for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? (Aredia, Zometa, XGEVA) Yes ☐ No ☐		Are you taking or set to start taking an antiresorptive agent for osteoporosis or Paget's disease? (Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) Yes ☐ No ☐	
Please list all medications, including over the counter medications and supplements, you're currently taking.			Are you pregnant or nursing?

Medical History

Do you have or have you had:

Cancer Yes ☐ No ☐	Heart disease Yes ☐ No ☐	Congestive heart failure Yes ☐ No ☐
Arthritis Yes ☐ No ☐	Chest pain Yes ☐ No ☐	Damaged valves in transplanted heart Yes ☐ No ☐
Stroke Yes ☐ No ☐	Arteriosclerosis Yes ☐ No ☐	Congenital heart defect Repaired ☐ Unrepaired ☐ No ☐
Ulcers Yes ☐ No ☐	Infective endocarditis Yes ☐ No ☐	Artificial heart valve Yes ☐ No ☐
Heart attack Yes ☐ No ☐	Damaged heart valves Yes ☐ No ☐	Rheumatic heart disease Yes ☐ No ☐
Hemophilia Yes ☐ No ☐	Joint replacement Yes ☐ No ☐	Severe/rapid weight loss Yes ☐ No ☐
Anemia Yes ☐ No ☐	Pacemaker Yes ☐ No ☐	Diabetes Type 1 ☐ Type 2 ☐ No ☐
Asthma Yes ☐ No ☐	Blood transfusion Yes ☐ No ☐	Hepatitis/liver disease Yes ☐ No ☐
Bronchitis Yes ☐ No ☐	Abnormal bleeding Yes ☐ No ☐	Chemotherapy/Radiation Yes ☐ No ☐
Emphysema Yes ☐ No ☐	Epilepsy/seizures Yes ☐ No ☐	Autoimmune disease Yes ☐ No ☐
COPD Yes ☐ No ☐	Tuberculosis Yes ☐ No ☐	Neurological disorder Yes ☐ No ☐
Sinus trouble Yes ☐ No ☐	Recurrent infections Yes ☐ No ☐	G.E. reflux (persistent heartburn) Yes ☐ No ☐
STD/STI Yes ☐ No ☐	Osteoporosis Yes ☐ No ☐	Systemic lupus erythematosus Yes ☐ No ☐
Substance abuse Yes ☐ No ☐	Thyroid problems Yes ☐ No ☐	Abnormal blood pressure High ☐ Low ☐ No ☐
AIDS/HIV Yes ☐ No ☐	Kidney problems Yes ☐ No ☐	Persistent swollen neck glands Yes ☐ No ☐
Severe headaches Yes ☐ No ☐	Excessive urination Yes ☐ No ☐	Mental disorder (including EDs) Yes ☐ No ☐
Have you ever had surgery? (Joint replacement, ACL, organ donation, heart, etc.)		
If you have any disease, condition, or previous surgery not listed above, or marked yes to any condition, please give us details.		

Emergency Contact

Name	Phone Number	Relationship to Patient

Office Policy

1. We accept both patients who do and do not participate in insurance plans. Regardless of insurance status, the fees associated with any treatment, product, or appliance will be due at the time of service.

We make an honest effort to give an estimate of what you can expect to pay. Additionally, we provide the courtesy service of submitting insurance claims on your behalf. Though we can estimate your expected payment, your insurance company makes final determinations. The patient is responsible for any outstanding balance not paid by the insurance company. If a check is returned from the bank, you will incur a $50.00 charge.

2. After 90 days, all accounts not paid in full may be sent to a collection agency and will be assessed a fee of $50.00. The patient will be responsible for all collection costs, attorney fees, and court costs. We reserve the right to cancel any appointment under an account which is delinquent.

3. In order to treat you effectively and efficiently, we make every effort to arrange a time convenient for you to manage your dental health care. We aim to give you the time and attention you need when in our office. Please help us achieve this goal by being punctual for your appointment. If you are more than ten (10) minutes late for your appointment, we may need to reschedule you to allow enough time for your treatment. If we are able to see you the same day, we may alter the treatment we planned for that time.

4. You are a valued patient and we ensure that your appointment time is reserved especially for you. We make every effort to honor all time commitments and expect patients to extend the same courtesy to us. In order to know we can expect you, we require all patients to confirm their reserved appointments within two (2) days of their appointment time. An appointment not confirmed by the day prior to the reserved time may be released to another patient.

5. All patients under 18 years old must be accompanied by a parent or guardian to every appointment. The parent or guardian who accompanies the child to his/her appointment will be expected to settle any balance on the account.

6. Out of respect for all our patients, we require a phone call two (2) business days in advance of your reserved appointment to cancel or reschedule your appointment time. Canceling within two business days is considered short notice. If you cancel or reschedule on short notice, or do not arrive for your appointment, you may be assessed a fee; the fee will be dependent on the amount of time reserved and will not be less than $50.00.

If you fail to appear or short notice cancel three (3) times, we will not reserve another specific appointment time for you. You will be placed on our short call list and an appointment reservation deposit may be collected for future appointments. The appointment deposit will go towards your out of pocket cost of treatment. For patients who give short notice to cancel or who fail to appear, this deposit will be forfeited.

7. We will gladly assist you in filling out the necessary forms to maximize your dental benefits, as well as discuss financial options. If you have any questions, please talk to a member of our Administration Team.

I acknowledge that I have read and agree to abide by the Office Policy as outlined above. I verify I am at least 18 years old and am the patient/patient's legal guardian.

Patient/Guardian's Signature: _____ Date _____

If signed by a parent/guardian, relationship to patient: _____

Authorization for Disclosure of Personal Health Information

Patient Record of Disclosures

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request a restriction on uses and disclosures of your protected health information, to require confidential communications, or a communication of your health information be made by alternative means, such as sending correspondence to your office instead of your home. (These requests must be made in writing and sent to our office.*)

Patient's Name: _____ Date of Birth: _____

I give permission to Gentle Dental Family Dentistry to share my protected health information with the following:

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

I acknowledge that I have read and understand the Patient Record of Disclosures. I give my permission for the above person(s) to assist me with my healthcare, including, but not limited to, treatment information, treatment plans, billing, payments, prescription drug information, and other information considered confidential. I understand that once information about me leaves this office according to the terms of this authorization, Gentle Dental Family Dentistry has no control over how it will be used by the recipient. I am aware that at that point, my information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. I understand that I have the right to a copy of this signed authorization which will be given to me upon my request. Gentle Dental Family Dentistry may share my health information with the above until I revoke the authorization in writing*.

Patient/Guardian's Signature: _____ Date _____

If signed by a parent/guardian, relationship to patient: _____

*Requests and revocations of this authorization may be sent to Lennie, Gentle Dental Family Dentistry's Office Manager, at 3276 West Rd, Trenton, MI 48183.

1. You have the right to revoke or cancel this authorization at any time, except to the extent information has already been shared based on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, submit your request in writing to Lennie, Gentle Dental Family Dentistry's Office Manager, at 3276 West Rd, Trenton, MI 48183.

2. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized our office to disclose information about you to a third party. If you refuse to sign and have authorized our office to disclose information about you to a third party, such as an insurance company, we have the right not to treat you or accept you as a patient in our practice.

3. Once information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. If you revoke this authorization, it will not affect any use or disclosures permitted by your authorization while it was in effect.

4. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our office may deny access if we reasonably believe access could cause harm to you or another individual. If access is denied, you may request a second opinion by a licensed healthcare professional at your expense.

5. You have a right to a copy of this signed authorization in written form.

6. You may be contacted for a variety of purposes using the information you have provided. These include, but are not limited to, appointment information, reminders, and information considered marketing. By signing this Notice, you are agreeing to accept communication from our office on any and all phone numbers, emails, devices, and platforms you have provided for, but limited to, the aforementioned purposes. For any landline or cellular phone calls this office or any service providers place to me, I consent and agree that those calls may be automatically dialed and that this office and it's service providers may use recorded messages. I agree to be contacted by the means I provide for myself and/or my children.

7. We may use or disclose your health information when we are required to do so by law. We also may disclose your health information in the following circumstances; if we reasonably believe you are a victim of abuse, neglect, domestic violence, or other crimes, to military personnel under certain circumstances, to authorized federal officials when required for national security activities, to correctional institutions or law enforcement officials having lawful custody, to an emergency contact or personal representative in the event of your incapacity or emergency circumstance, in connection with our healthcare operations, and to provide you with appointment reminders.

Rights to Personal Health Records and Disclosures

Access: You have the right to look at or receive copies of your health information with limited exception. You may request copies in a format other than photocopies and we will use your requested format when it is reasonable to do so. Requests for health information must be made in writing and sent to Lennie, Gentle Dental Family Dentistry's Office Manager, at 3276 West Rd, Trenton, MI 48183. You will be charged a reasonable, cost-based fee for expenses incurred while processing your request. You will be charged $35.00 for every request processed and an additional charge for postage if you would like your documents mailed. Another option is to request an explanation or a summary of your health information which will be processed for a fee.

Disclosures: You have a right to an accounting of the disclosures of your protected dental information by our office. The maximum disclosure accounting period is the six years immediately preceding the accounting request. We are not required to provide an accounting of disclosures for treatment, payment, or dental care operations, to you or your personal representative, for notification of or to persons involved in our dental care or payment for dental care, for disaster relief, or for facility directories, pursuant to an authorization, of a limited data set, for national security or intelligence purposes, to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody, or incidents otherwise permitted for required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities. If requested more than once in a 12 consecutive month period, you will be charged a reasonable, cost-based fee.

Restrictions: You have the right to request additional restrictions on our use and disclosures of your health information, however, we are not obligated to agree.

Alternative Communication: You have the right to request we alter our use or disclosure of your health information by changing our means and location of communications. For example, you may request that we send your protected health information to an address that is not your home or call you on a number that is not your landline or cell phone. Requests for alternative communication must be made in writing, specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location.

Amendments: You have the right to request we amend your health information. Your request must be made in writing and explain why the information should be amended. We may deny your request.

QUESTIONS AND COMMENTS

If you would like additional information about our privacy practices, have questions or comments, are concerned we may have violated your privacy rights, or disagree with a decision we made about access, restrictions, alternative communications, or amendments, please contact our office using the 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, of which we will provide you the address upon request. We will not retaliate if you choose to file a complaint with us or the DHHS.

I understand I can obtain this Notice on request. I understand and agree to the terms outlined in this document. I verify I am at least 18 years old and am the patient/patient's legal guardian.

Patient/Guardian's Signature: _____ Date _____

If signed by a parent/guardian, relationship to patient: _____