# FAMILY DENTISTRY
## Annette Skowronski, DDS, FAGD, PC

### PATIENT INFORMATION

Name _____ S.S.# _____ Date _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Birthdate _____ Gender: Male _____ Female _____ E-Mail _____

Home Phone (____) _____ Cell Phone (____)_____ Work Phone (____)_____
Do you prefer to receive calls at: Home ____ Work ____ Cell ____ No Preference ____

Family Status: Married ____ Single ____ Widowed ____ Minor ____ Other ____

### RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____

Address (if different than patient's) _____

Home Phone (if different than patient's) (____) _____ Work Phone (____) _____

**IN CASE OF A MEDICAL EMERGENCY** while in our office for dental treatment whom may we contact?

_____ _____ _____
Name Phone Relationship

### DENTAL HISTORY

Date of Last Dental Visit: _____ Previous Dentist: _____

Have you ever had any complications following dental treatment? Yes ____ No ____
(If yes, please explain: _____

Are there any dental concerns that need to be addressed? _____

Are you happy with your smile? _____

# HEALTH HISTORY

**Have you ever had any of the following? Please check those that apply:**

___AIDS
Allergies:
__Codeine
__Penicillin
__Latex
___Anemia
___Arthritis
___Artificial Joints
(date_____)
___Asthma
___Cancer
(Tumors/Growths)
___Diabetes
___Dizziness/Fainting
___Epilepsy
___Excessive Bleeding
___Glaucoma
___Hay Fever
___Headaches
___Head Injuries
___Heart Disease
___Heart Murmur
___Hepatitis
___High Blood Pressure
___Kidney Disease
___Liver Disease
___Mental Disorders
___Nervous Disorders
___Pacemaker
___Radiation Treatment
___Respiratory Problems
___Rheumatic Fever
___Sinus Problems
___Stomach Problems
(Ulcers)
___Stroke
___Thyroid Problems
___Tuberculosis

Any other health issues, please list: _____

_____

Do you have any other allergies? Please list: _____

Are you Pregnant? ____ If so, due date _____

Do You Take Birth Control Pills? ____ Hormone Replacement? ____ Use Tobacco? _____ Alcohol? _____

Have you been admitted to a hospital or needed emergency care during the past two years? ___Yes ___No
(If yes, please explain)_____

_____

Are you now under the care of a physician? ____Yes ____No
(If yes, please explain)_____

_____

List of current medications and dosages _____

_____

Name of Physician _____ Phone _____

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I/or my dependent ever have any change in my/their health, I will inform the doctors at the next appointment without fail.**

X_____ Date _____
Signature of patient, parent or guardian

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have Dental Insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. All co-pays and deductibles are due at time of service. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____ _____
Signature of patient, parent or guardian | Relationship to patient | Date

## REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _____

## RELEASE OF INFORMATION

I authorize the office of Dr. Skowronski, when necessary, to release dental x-rays and at times dental history to dental and/or medical specialists for my treatment, via phone, email, mail or fax.

_____ _____
Signature of patient, parent or guardian | Date

## Patient Acknowledgement and Consent Form

Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with effective April 14, 2003, the new federal law known as the Health Insurance certain rules regarding maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to 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 and provide x-rays 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 (please print): _____

Date: _____

### Patient Consent

Please sign this form below under the heading "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 (please print): _____

Date: _____

## Payment Policy

Payment for services is due at the time services are rendered. For your convenience, we accept cash, checks, money orders, VISA, MasterCard, Discover, American Express, and Care Credit.

We will file your insurance claims as a courtesy; however you remain responsible for payments not covered or rejected.

Returned checks will be charged a $50.00 handling fee.

A charge of $20.00 per half hour of appointment time will be incurred for missed appointments and appointments canceled within a 48 hour (2 business days) advanced notice.

Dr. Skowronski is committed to providing the best treatment to her patients. Our prices are representative of the usual and customary charges for this area. Thank you for understanding our payment policy. If you have any questions or concerns, please call our office for an explanation.

I hereby confirm that I have read the above payment policy and agree to abide by its guidelines.

**Date:** _____

**Printed Name:** _____

**Signature:** _____