Patient Information

Date ______________ Referred by________________________________

Patient Name_______________________ _____Social Security #___________________________

Gender (M/F) _______ Marital Status ___________________Birth Date _____________________

Driver's License #______________________E-mail Address______________________________

Address_____________________________City_________________State______Zip__________

Home Phone _______________Work Phone______________ Other ________________________

Patient's Employer _____________________________________Phone # _________________

Address______________________City_________________State_______Zip__________

Responsible Party (if other than patient)

Name_______________________________________ Relationship to patient _________________

Gender(M/F) _______Marital Status _____________________________Birth Date ____________

Driver's License # _________________________Social Security # __________________________

Address ______________________________City_________________State______Zip__________

Home Phone_________________Work Phone___________________ Other _________________

Employer ____Phone # _____________________

Address________________________City___ _____________State______Zip__________

Dental Insurance Information

Primary Insurance Name ____________________________ **Phone #** _____________________

Address_________________________City________________State______Zip__________

Name of Insured______________________________________Relationship to patient ____________

Insured's Birth Date ________________ID# _________________________Group # ____________

Insured's Address_______________________City________________State______Zip__________

Insured's Employer ____Phone #____________

Address ________________________City________________State______Zip__________

Secondary Insurance Name ___________________________ **Phone #**_____________________

Address ________________________City________________State______Zip__________

Name of Insured _____________________________________Relationship to patient ___________

Insured's Birth Date _______________ID # __________________________Group # ____________

Insured's Address ______________________City________________State_____Zip__________

Insured's Employer ____Phone # ________________

Address _________________________City________________State_____Zip__________

Health Questionnaire

Name___________________________________ Date________________

Please circle and ***explain*** your answers. You may use the back of this sheet, if needed.

Have you previously taken or currently taking the following:
Fosamax, Bon, Bonefos Ostac, Actonel, Aredia, Bon-iva, Zometa, Shelid, Didronel

Please list any kind of medicine, drugs, herbal supplements or vitamins currently being taken ____

Are you sensitive or allergic to latex material, drugs or medicine such as aspirin, penicillin or novacaine? Yes No

Do you use tobacco products? Yes No

Have you ever been given antibiotic pre-medication before a dental treatment? Yes No
Explain ____
Have you been under the care of a physician during the past 2 years? Yes No
Explain ____
Have you been a patient in a hospital during the past 2 years? Yes No
Explain ____
Have you had any major surgery or operations in the last 2 years? Yes No
Explain ____
Have you ever had excessive bleeding requiring special treatment? Yes No
Explain ____

Do you have any of the following conditions?

Aids	Epilepsy, Seizures	Mitral Valve Prolapse
Anemia	Excessive Bleeding	Pacemaker/Defibrillator
Arthritis	Glaucoma	Psychiatric Treatment
Artificial Joints	Heart Murmur	Radiation Treatment
Artificial Valve	Heart Trouble	Rheumatic Fever
Asthma	HIV	Sinus Problems
Cancer	Hepatitis A, B, or C	Stomach Problems
Cortisone Medicine	High Blood Pressure	Stroke
Diabetes	Jaundice	Tuberculosis
Emphysema	Kidney Disease	Unintentional Weight Loss

Have you ever experienced any unfavorable reaction or result from previous medical or dental treatment, anesthetics, drugs, or medications? Yes No
Explain ____
Have you ever been treated for cancer? Yes No
Explain ____

Women: Are you pregnant now? Yes No
Are you taking birth control medication? Yes No

Do you have any other information you think we should know about?

General Consent Form

Patient Name_______________________________________ Date of birth________________

I freely consent to dental health care – which may include procedures, treatment options, test, drugs, and treatments that I may receive at the Hosack, Bieszka and Halverson (HBH) dental office. I understand that I have a right to discuss it with my health care provider. I understand I will be informed of all reasonable treatment options. I know that the practice of dentistry is not an exact science and outcomes may be different for each patient. For example, anyone might have an adverse reaction to local anesthetic.

Human Immunodeficiency Virus (HIV) is the virus that causes AIDS (Acquired Immune Deficiency Syndrome). I understand that under Michigan law, an HIV test may be done on a patient if any health care worker or emergency responder contacts that patient's blood or other body fluids through the skin, in an open wound, or through the mucous membranes. If this type of contact occurs, I understand that my blood can be tested without my consent. If a test is done, I understand that I will be informed of the test results. I will receive advice about what to do, what the results mean and what treatment, if any, is indicated.

Except as barred by any agreement between my insurance company and HBH or by state or federal law, I agree to be responsible for my co-payments, deductibles or other charges for medical or dental services not covered or paid by insurance or other third party payers. I permit HBH to file claims with third party payers for payment and assign all rights and benefits to HBH as fitting. I will help HBH to follow up on these claims. I further agree, subject to state or federal law, to pay all court costs and interest in the event HBH has to take action to collect for services not covered by insurance or other third party payers because of my failure to pay for these services.

I confirm that I have read and understand this form or that it has been read and explained to me. I know the contents and agree with the terms in this form. I understand this form is valid for any care given by HBH until it is actively revoked by my legal representative or me.

As a new patient, I understand that my credit report may be checked.

_________________________________ ___________________
Signature of patient Date

_____________________________ _____________________________ ________________
Name of parent/guardian Signature of parent/guardian Date

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Relationship to patient (if patient is under 18 years old)