ALLEN PARK DENTAL CARE

SZALAI & SZALAI DDS

PATIENT INFORMATION

Name _____ I prefer to be called _____

Address _____ Cell Phone _____

City _____ Zip _____ Home Phone _____

Email _____ Work Phone _____

Employer _____ SS # _____

Date of Birth _____ Marital Status (please circle) S M D W

How did you hear about our office? _____

How may we contact you for appointment reminders? (please circle all that apply)

email work phone home phone cell phone cell phone text message

INSURANCE INFORMATION

Policy Holder's Name _____ Date of Birth _____

Employer _____ SS # _____

Insurance _____ Secondary Insurance _____

DENTAL HISTORY

Are you have any of the following problems?

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, jaw joint, neck pain
- ☐ Dry mouth, difficulty swallowing
- ☐ Teeth or filling breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Sleep apnea, snoring

Do you have or have you had any of the following?

- ☐ Dentures/Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Do you smoke or chew tobacco? How much?

_____

Why did you leave your previous dentist?

_____

If you could change your smile, you would:

- ☐ Make them whiter and brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings w/tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Please rate on a scale of 1-10 (10 is highest):

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where is your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

_____

What is the most important thing to you about your dental visit today?

_____

MEDICAL HISTORY

Please circle "Yes" or "No" to all questions below.

Yes No Are you in good health?

Yes No Have you been told to take premedication/antibiotics before a dental treatment?

If yes, for what reason? _____

Yes No Any change in your health within the last year? _____

Yes No Hospitalized or a serious illness within the last 5 years? _____

Yes No Being treated by a physician now? For what? _____

Yes No Do you have any allergies? _____

Do you have or have you ever had?

Yes No Shortness of breath
Yes No Sinus Problems
Yes No Asthma
Yes No Emphysema
Yes No Tuberculosis
Yes No Sleep apnea/snoring

Yes No High Blood Pressure
Yes No Heart Disease
Yes No Heart Murmur
Yes No Mitral Valve Prolapse
Yes No Stroke
Yes No Hearth Attack
Yes No Heart Defect
Yes No Pacemaker
Yes No Prosthetic Heart Valve
Yes No Chest Pain
Yes No Anemia
Yes No Bleeding problem
Yes No HIV positive/AIDS/ARC
Yes No Hepatitis A B or C
Yes No Stomach problem/ulcer
Yes No Diabetes
Yes No Kidney/bladder-disease
Yes No Thyroid/adrenal disease
Yes No Liver Disease
Yes No Herpes/Cold sore/ fever blister
Yes No Human papillomavirus

Yes No Seizures
Yes No Dizziness, fainting
Yes No Depression
Yes No Anxiety

Yes No Surgeries
Yes No Artificial Joint

Yes No Cancer
Yes No Radiation
Yes No Chemotherapy

Do you take or have you ever taken:

Yes No Recreational drugs
Yes No Alchohol
Yes No Tobacco in any form
Yes No Fosomax/ Osteoporosis meds
Yes No Contraception/birth control
Yes No Vitamins
Yes No Medications - list below

_____ to treat _____
_____ to treat _____
_____ to treat _____
_____ to treat _____
_____ to treat _____
_____ to treat _____

Do you have or have you had any other medical problems not listed above? _____

_____

_____

Patient Signature (guardian if a minor) *Date*

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2003, the federal law know as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the 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. this Notice of Privacy Practices contains the information that HiPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement discussed above) us to first 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 of 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.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to our 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*

FOR OFFICE USE ONLY:
Patient Refused to Sign

The following circumstances prohibited the patient from signing acknowledgement:

An emergency situation prevented the patient from signing the acknowledgement:

Office Personnel (Signature)	*Office Personnel Name (print)*	*Date*

PATIENT CONSENT

Please sign this form below under the heading "consent" to 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 necessary in connection with my treatment. I understand that such disclosures may not be of the type listed about. I consent to the use of a testimonial I write and/or before and after photos for education and marketing purposes.

Patient Signature	*Patient Name (please print)*	*Date*

ALLEN PARK DENTAL CARE

NOTICE OF PRIVACY PRACTICES

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.

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 (MM/DD/YR), and will remain in effect until we place 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare options. 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.

Michigan Dental Patient Consent Law: We are required by Michigan Law to obtain your written consent prior to making certain disclosures of your health information.

Y**our Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may 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 you 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 wit 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 judgement 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.

Nation 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).

PATIENT RIGHTS

Access: You have the right to loo 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 the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. 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. for each page, $ 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.

Restriction: 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 restriction, 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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend you 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.

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 you 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: Administration

Telephone: 313-928-2323

Fax: 313-928-3329

E-mail: smiles@yourbestsmile.com

Address: 5329 Allen Rd., Allen Park MI 48101