Brian G. Tyler DDS
Bruce E. Kennedy DDS
Chase B. Walby DDS
Mike Papastamatis DMD

UNIVERSITY *Dental* ASSOCIATES

248.652.9116
435 Pine Street
Rochester, MI 48307
www.udadentist.com

Date ____________

PATIENT INFORMATION...

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name ____________ M.I. ____ Last Name ____________ Preferred Name ____________

Sex: ❑ Male ❑ Female Birth Date ________ Age ____ Soc. Sec. # ____________ E-mail ____________

Street ____________ City ____________ State ______ Zip ______

Home Tel.(_____) ____________ Cell.(_____) ____________ Work. (_____) ____________

How would you prefer our office confirm your appointment? ❑ Home Tel. ❑ Cell ❑ Work Tel. ❑ E-Mail Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By ________ FIRST NAME ________ LAST NAME Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist (Prev) ________ FIRST NAME ________ LAST NAME Medical Doctor ________ FIRST NAME ________ LAST NAME

Driver's Lic.# ____________ Nearest relative not living with you ________ FIRST NAME ________ LAST NAME Tel.(_____) ____________

Employer ____________ Bus. Tel.(_____) ____________

In case of emergency, please contact ____________ Tel. (_____) ____________ Relation ____________

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other ____________

Name ________ FIRST NAME ________ LAST NAME S.S.# ____________ Birth Date ________ Age ____ Tel.(_____) ____________

Street ____________ City ____________ State ______ Zip ______

Employer ____________ Bus. Tel.(_____) ____________

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name ____________ Relation ____________ S.S.# ____________ Birth Date ____________

Street ____________ City ____________ State ______ Zip ______

Tel. (_____) ____________ Employer ____________ Bus. Tel.(_____) ____________

INSURANCE INFORMATION...

Student: .... ❑ Full Time ❑ Part Time ❑ Not........ School Name and Address ____________ SCHOOL ADDRESS

Marital Status: .... ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated ____________ CITY ________ STATE ZIP

Employed: .... ❑ Full Time ❑ Part Time ❑ Retired ❑ Not........

PRIMARY INSURANCE COMPANY...

Insurance Type: ❑ **Dental**

Employer ____________

Bus. Address ________ STREET NAME ________ CITY ________ STATE ZIP

Bus. Tel.(_____) ____________ Plan ____________

Ins. Co. Name ____________ I.D. # ____________

Address ____________

________ CITY ________ STATE ZIP Tel.(_____) ____________

Group # ____________ **Group Name** ____________

Insured Party ________ FIRST NAME ________ LAST NAME Relation ____________

Sex: ❑ M ❑ F Birth Date ____________ S.S. # ____________

Street ____________ City ____________

State, Zip ______ ____________ Tel.(_____) ____________

SECONDARY INSURANCE COMPANY...

Insurance Type: ❑ **Dental**

Employer ____________

Bus. Address ________ STREET NAME ________ CITY ________ STATE ZIP

Bus. Tel.(_____) ____________ Plan ____________

Ins. Co. Name ____________ I.D. # ____________

Address ____________

________ CITY ________ STATE ZIP Tel.(_____) ____________

Group # ____________ **Group Name** ____________

Insured Party ________ FIRST NAME ________ LAST NAME Relation ____________

Sex: ❑ M ❑ F Birth Date ____________ S.S. # ____________

Street ____________ City ____________

State, Zip ______ ____________ Tel.(_____) ____________

DENTAL INFORMATION...

Reason for today's visit ____________ Are you in pain? ❑ Yes ❑ No, For How Long? ____________

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw
❑ Red, swollen, or bleeding gums
❑ A removable dental appliance
❑ Blisters / sores in or around the mouth
❑ Prolonged bleeding from an injury / extraction
❑ Recent infections or sore throat
❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting

❑ Lost / broken filling(s)
❑ Teeth grinding / clenching
❑ Ringing in ears
❑ Broken / chipped tooth
❑ Gum disease
❑ Other

❑ Stained teeth
❑ Locking jaw
❑ Bad breath
❑ Burning tongue / lips
❑ Toothache

❑ Difficulty closing jaw
❑ Difficulty opening jaw
❑ Loose / shifting teeth
❑ Food caught between teeth
❑ Swelling / lumps in mouth

Last dental exam ____________ Last dental x–rays ____________ Times a day you brush? ______ Times a week you floss? ______

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❑ Yes ❑ No

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

Patient's Name

MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No • Are you under the care of a physician? ❑ Yes ❑ No; if Yes, Dr's Name________

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y N
- ❑ ❑ Alcohol abuse history
- ❑ ❑ Anemia
- ❑ ❑ Arthritis/joint disease
- ❑ ❑ Artificial joint replacement
- ❑ ❑ Asthma
- ❑ ❑ Blood disease/disorder
- ❑ ❑ Cancer/Radiation/Chemotherapy
- ❑ ❑ Diabetes
- ❑ ❑ Excessive bleeding
- ❑ ❑ Fainting spells
- ❑ ❑ Glaucoma/eye disease
- ❑ ❑ Growth or tumors
- ❑ ❑ Hay fever/sinus problems
- ❑ ❑ Hepatitis
- ❑ ❑ Jaundice/liver disease
- ❑ ❑ Kidney trouble
- ❑ ❑ Mental health problems

Y N
- ❑ ❑ Mitral valve prolapse
- ❑ ❑ Pacemaker
- ❑ ❑ Respiratory problems
- ❑ ❑ Stomach ulcers/problems
- ❑ ❑ Stroke
- ❑ ❑ Thyroid trouble
- ❑ ❑ Tuberculosis
- ❑ ❑ Heart valve replacement
- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ Chest pain/angina
- ❑ ❑ Heart attack(s)
- ❑ ❑ Irregular heart beat
- ❑ ❑ Heart surgery
- ❑ ❑ Pneumonia/bronchitis/chronic cough
- ❑ ❑ Chronic fatigue/night sweats
- ❑ ❑ Trouble climbing 1-2 flights of stairs

Y N
- ❑ ❑ Are you immunosuppressed? (possibly from transplant surgery)
- ❑ ❑ Snoring/sleep apnea
- ❑ ❑ Emphysema
- ❑ ❑ Do you smoke?
- ❑ ❑ Do you use chewing tobacco?

*If you smoke or use tobacco, what **IS** your daily intake?* ________

If you no longer use tobacco products, how long ago did you quit? ________

*What **WAS** your daily intake?* ________

How long did you smoke? ________

Y N
- ❑ ❑ Blood transfusion
- ❑ ❑ Bruise easily
- ❑ ❑ A history of drug abuse
- ❑ ❑ Convulsions/epilepsy
- ❑ ❑ Sexual transmitted diseases
- ❑ ❑ Swollen ankles
- ❑ ❑ Low blood sugar
- ❑ ❑ Are you on dialysis?
- ❑ ❑ Osteoporosis/osteopenia
- ❑ ❑ Osteonecrosis
- ❑ ❑ Contagious diseases
- ❑ ❑ Delay in healing
- ❑ ❑ Are you on a diet?
- ❑ ❑ Autoimmune diseases
- ❑ ❑ HIV/AIDS
- ❑ ❑ Have you, or a member, had any unusual or serious reactions to general anesthesia?
- ❑ ❑ Autism spectrum

MEDICATION & ALLERGIES...

Preferred Pharmacy Name ________ Telephone (____) ________

Are you now taking, or have you ever taken: ***In lieu of completing the Medication list below, I will be bringing a list of medications with me.*** ❑

Y N
- ❑ ❑ Anti-Anxiety pills
- ❑ ❑ Diet pills
- ❑ ❑ Blood thinners (Coumadin, Aspirin, Advil)
- ❑ ❑ Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)

Y N
- ❑ ❑ Pain killers (including aspirin)
- ❑ ❑ Tranquilizers

Y N
- ❑ ❑ Muscle relaxers
- ❑ ❑ Insulin

Y N
- ❑ ❑ Stimulants
- ❑ ❑ Antidepressants

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y N
- ❑ ❑ Sulfa drugs
- ❑ ❑ Valium or other tranquilizers
- ❑ ❑ Amoxicillin

Y N
- ❑ ❑ Local anesthetic (numbing med)
- ❑ ❑ Latex
- ❑ ❑ Iodine

Y N
- ❑ ❑ Aspirin
- ❑ ❑ Sulfites

Y N
- ❑ ❑ Codeine or other narcotics
- ❑ ❑ Antibiotics

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: ________

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X ________ **Signature of patient** *(Parent or Guardian if Minor)*

X ________ **Reviewed by**

X ________ **Date**

Insurance Authorization & Assignment: I authorize University Dental Associates to furnish information to insurance carriers for the purpose of reviewing my dental coverage and/or for the processing of claims for services rendered to me or my dependent. I assign to University Dental Associates all payments for dental related services rendered by them, by me in writing. **I understand and agree that I am responsible for any amount not covered by my insurance.** I also agree to reimburse University Dental associates the fees of any collection agency, attorney fees, and court costs incurred in such collection efforts. I will also be responsible for any charges for returned checks due to insufficient funds.

LATE CANCELLATION/NO SHOW POLICY: I acknowledge that a **LATE CANCELLATION** is when I have cancelled an appointment with less than 48-hour notice and that a **NO SHOW** is when I do not show for my appointment. Either will result in a $30.00 fee.

NOTICE OF PRIVACY PRACTICES: I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

My signature below attests to my authorization & acknowledgement of the 3 sections above
(Insurance Authorization & Assignment, Late Cancellation/No Show Policy & Notice of Privacy Practices)

Signature:________ Date:________

University Dental Associates
435 Pine St
Rochester, MI 48307
248-652-9116

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have received a copy of University Dental Associates Notice of Privacy Practices.

____

Please Print Name (patient name or name of parent or guardian)

____ Date ____________________

Signature (patient name or name of parent or guardian)

I <u>ALLOW/DO NOT ALLOW</u> University Dental Associates to share my Health History and Medical Information with the following family members:

Please check one:

☐ Allow ☐ low **Name** ________________________________ **Relationship** _________________

☐ Allow I☐ ow **Name** ________________________________ **Relationship** _________________

____ ______________________________

Signature (patient name or name of parent or guardian) Date

University Dental Associates., P.C.

FINANCIAL POLICY/CONTACT INFORMATION UPDATE FORM

Our doctors and staff are proud to be a team whose primary mission is to deliver the finest and most comprehensive dental services available today. We are concerned about your dental care and want to ensure you that it is performed in the most responsible manner. In order to assist you with the investment in your dental health, the following is our financial policy.

Payment is due in full at the time of service. If you have insurance, all ESTIMATED copays, deductibles, and non-covered services are due at the time of service. For your convenience we accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit. **A $35.00 fee will be assessed on all returned checks.**

Regarding Insurance

Patients **MUST** provide the office with accurate insurance billing information **AT THE TIME** of their appointment. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. The coverage a patient will receive depends upon the quality of the plan purchased by his/her employer, not the fees of the Doctor. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit. Due to constantly changing insurance regulations, benefits, and deductibles, we are only able to **ESTIMATE** your insurance balance. We will be happy to file a pre-authorization for any services upon request. If your insurance company has not paid your account in full within 60 days, the balance may automatically be transferred to your account. Further insurance appeal becomes the patient's responsibility. Please be aware that some services (if not all services) may be non-covered services and not considered reasonable and necessary under your particular dental plan. We will send no more than two billing statements to the address you provide. If we do not receive payment by the second billing cycle, your account will be transferred to a collection agency. **A monthly interest rate of 1.8% will be applied to your account on any unpaid balances.**

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients. Please be aware that some services (if not all services) may be non-covered services and not considered reasonable and customary or necessary under your particular dental plan. Our fees are the Usual and Customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of Usual and Customary rates.

Minor Patients

The adult accompanying a minor, the parent (guardian) is responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-arranged.

MISSED APPOINTMENTS

We ask that a 48 hour notice be given for cancellation of appointments. A $30.00 broken appointment fee will be charged for all appointments cancelled with less than 48 hour notice or if the patient does not arrive at their appointed time.

CONTACT INFORMATION/INSURANCE UPDATE

Current Address:____

Current Phone:______________________________ **Current Email**:______________________________

Insurance Changes (Please provide Subscriber name, Insurance name, phone number, ID Number and Group number):

____

____

Thank you for taking the time to update your information and read our financial policy.

By signing below, I agree to the above financial office policy.

Signed:____________________________________ Date:____________________