Brian G. Tyler DDS
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UNIVERSITY Dental ASSOCIATES

248.652.9116
435 Pine Street
Rochester, MI 48307
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PATIENT INFORMATION...

Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

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.(____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

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

MEDICAL HISTORY...

Patient's Name

Are you in good health? ❑ Yes ❑ No • Are you under the care of a physician? ❑ Yes ❑ No; if Yes, describe _____

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	
❑	❑	Joint replacement
❑	❑	Mitral valve prolapse
❑	❑	Heart valve replacement
❑	❑	High blood pressure
❑	❑	Low blood pressure
❑	❑	Chest pain / Angina
❑	❑	Heart attack(s)
❑	❑	Irregular heart beat
❑	❑	Cardiac pacemaker
❑	❑	Heart surgery
❑	❑	Pneumonia / Bronchitis / Chronic cough
❑	❑	Chronic fatigue / Night sweat
❑	❑	Trouble climbing 1-2 flights of stairs
❑	❑	Mental health problems
❑	❑	Asthma
❑	❑	Are you immunosuppressed? *(possibly from transplant surg.)*

Y	N	
❑	❑	Hay fever / Sinus problems
❑	❑	Snoring / Sleep apnea
❑	❑	Respiratory problems
❑	❑	Tuberculosis
❑	❑	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
❑	❑	Blood disorder
❑	❑	Bruise easily
❑	❑	A history of drug abuse
❑	❑	Eye disease / Glaucoma
❑	❑	Abnormal bleeding
❑	❑	Problems w/ immune system? *(possibly from med. / surg.)*
❑	❑	Jaundice / Liver disease
❑	❑	Hepatitis
❑	❑	Fainting spells
❑	❑	Convulsions / Epilepsy
❑	❑	Stroke
❑	❑	Thyroid trouble
❑	❑	Diabetes
❑	❑	A history of alcohol abuse
❑	❑	Sexually transmitted diseases
❑	❑	Swollen ankles

Y	N	
❑	❑	Low blood sugar
❑	❑	Kidney trouble
❑	❑	Are you on dialysis
❑	❑	Arthritis / Joint disease
❑	❑	Osteoporosis / Osteopenia
❑	❑	Osteonecrosis
❑	❑	Stomach ulcers
❑	❑	Contagious diseases
❑	❑	Delay in healing
❑	❑	Anemia
❑	❑	Tumor or growth
❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Are you on a diet
❑	❑	Autoimmune diseases
❑	❑	HIV / AIDS
❑	❑	Have you, or a family 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)
❑	❑	Pain killers (including aspirin)
❑	❑	Tranquilizers
❑	❑	Muscle relaxers
❑	❑	Insulin
❑	❑	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		Y	N		Y	N	
❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Aspirin	❑	❑	Codeine or other narcotics
❑	❑	Valium or other tranquilizers	❑	❑	Latex	❑	❑	Sulfites	❑	❑	Antibiotics
❑	❑	Amoxicillin	❑	❑	Iodine						

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**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. Payment is due in full at the time of service. An estimate of the charge for any procedure or surgery you may require will be given upon your request. If you have any dental insurance we will be glad to fill out the proper forms, but please complete the indentifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

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

X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

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

X _____ **Date**

I hereby 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.

X _____ **Signature of patient** *(Parent or Guardian if minor)*

X _____ **Date**

University Dental Associates., P.C.

FINANCIAL POLICY

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.

Thank you for taking the time to read our financial policy. Please let us know if you have any questions or concerns.

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

Signed:_____ Date:_____