MEDEMAENDODONTICS

New Patient Forms

The following information is confidential and for our records only.

Today's Date: _____

PERSONAL INFO

Name: _____
(Last) (First) (Middle initial) (Preference)

Address: _____

Home Phone #: (_____) _____ Work #: (_____) _____

Cell Phone #: (_____) _____ Email Address: _____

Date of Birth: _____ / _____ / _____ Age: _____ Sex: _____

EMPLOYMENT

Employer: _____ Occupation: _____

DENTAL INSURANCE

Insurance Company: _____ Subscriber of the Insurance: _____

Relationship to the Subscriber: _____ Subscriber's Employer: _____

Subscriber's ID or SSN #: _____ Subscriber's DOB: _____ / _____ / _____

SPOUSE/PARENT INFO

Spouse or Parent Name: _____

Home Address: _____

Home Phone #: (_____) _____ Cell #: (_____) _____

Work #: (_____) _____ Date of Birth: _____ / _____ / _____

Relationship to the patient: _____ Employer: _____

EMERGENCY CONTACT INFO

Name & Relation: _____ Home #: (_____) _____

Work Phone #: (_____) _____ Cell #: (_____) _____

DENTAL HISTORY

Referring Dentist: _____

Were you placed on medication by your dentist? Y N Prescription name: _____

Last Dental Visit: _____ What work was completed? _____

SEE OTHER SIDE

MEDEMAENDODONTICS

HEALTH INFO

Primary Care Physician Name: _____ Phone #: (_____) _____

Do you have/or had any of the following:

Artificial Bones / Joints / Valves	Y	N	Alcohol / Drug Abuse	Y	N
HIV / AIDS	Y	N	Arthritis / Joint Disease	Y	N
Diabetes	Y	N	Cancer / Chemotherapy / Radiation	Y	N
Blood Transfusion	Y	N	Colitis / Ulcers	Y	N
Congenital Heart Defect	Y	N	Difficulty Breathing / Bronchitis	Y	N
Heart Attack / Stroke / Bypass	Y	N	Emphysema / Tuberculosis	Y	N
Date: _____			Asthma	Y	N
Heart Murmur / Prolapsed Valve	Y	N	Epilepsy / Seizures / Fainting Spells	Y	N
Heart Surgery / Pacemaker	Y	N	Fever Blisters / Herpes / Cold Sores	Y	N
Date: _____			Bruise Easily	Y	N
High / Low Blood Pressure	Y	N	Contagious Diseases	Y	N
Infectious Mono	Y	N	Kidney Problems	Y	N
Hepatitis and Type: _____	Y	N	Psychiatric Treatment	Y	N
Liver Disease / Jaundice	Y	N	Sinus Trouble	Y	N
Rheumatic Fever / Heart Disease	Y	N	TMJ	Y	N
Irregular Heartbeat	Y	N	Osteoporosis	Y	N
Abnormal Bleeding	Y	N	Thyroid Problems	Y	N
Blood Disorder (Anemia)	Y	N	Hay Fever	Y	N
Eye Disease / Glaucoma	Y	N	Chest pain / Angina	Y	N
Venereal Disease	Y	N	Delay in Healing	Y	N
Gallbladder Trouble	Y	N	Chronic Fatigue	Y	N
Problems with Immune System	Y	N	Dialysis	Y	N
Low Blood Sugar	Y	N	Recent Tooth Pain/Scale 1-10: _____	Y	N

Do you generally use Nitrous (laughing gas) for dental procedures? Y N
Are you required to have a premedication prior to a dental appointment? Y N
Have you ever taken Bisphosphonate drugs? (medication for Osteoporosis) Y N If YES, please provide more info.

ALLERGIES

Y	N	Motrin (Ibuprofen)	Y	N	Codeine	Y	N	Latex
Y	N	Dental Anesthetics	Y	N	Clindamycin	Y	N	Penicillin

Additional Allergies: _____

Please list any prescription(s) or over the counter medication you are taking: (If you have a list we can photocopy it)

_____

_____

Additional comments concerning your health we should be aware of: _____

FOR WOMEN: Are you pregnant? Y N How many months: _____
Are you nursing? Y N OB Name: _____ Office #: (_____) _____

I UNDERSTAND THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM DR. MEDEMA OF ANY CHANGE IN MY MEDICAL STATUS.

I UNDERTAND THAT, ON THE DATE OF SERVICE, I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AS WELL AS PAYING ANY CO-PAY AND DEDUCTIBLE THAT MY DENTAL BENEFITS DOES NOT COVER.

WHEN YOU SCHEDULE AN APPOINTMENT WE CONSIDER THAT AS YOUR CONFIRMATION. WE WILL ATTEMPT A COURTESY CALL 1 – 2 DAYS PRIOR TO YOUR SCHEDULED TIME. HOWEVER, IF WE CANNOT REACH YOU OR YOU DO NOT RECIEVE THE MESSAGE, THE APPOINTMENT IS STILL YOUR RESPONSIBILITY.

Signature: _____ **Date:** _____
(Guardian if a minor)

Brent A Medema, DDS: _____ **Date:** _____

MEDEMAENDODONTICS

FINANCIAL AGREEMENT

Payment is due at the time services are rendered. For your convenience we accept cash, Visa, MasterCard, Discover, American Express, personal check, money order, registered check or CareCredit (see more details below).

We view your dental benefits as an entity that financially assists you with your dental care and finances. ***Your*** dental benefits are based on a contract between your employer (or subscriber's employer) and the dental benefits company. **Any deductible or estimated co-payment amount will be due at the time services are rendered.** As a courtesy we will be glad to file your claim for you if you provide 1) your ID or SSN for the subscriber of your insurance and 2) all required employer information. If the office is unable to verify your dental benefits information before treatment, you will be expected to make full payment for services rendered. Once we verify dental benefits status we will, as a courtesy, file the claim on your behalf. In the unfortunate event that your benefits company does not pay, the balance is your responsibility. **If payment for services rendered has not been received from your dental benefits company, within 45 days, the remaining balance for treatment is considered due and collectible from you.**

Balances (if any) after insurance pays must be payable **within 30 days** from the statement date. **Any balances out longer than 30 days are subject to collections.**

We reserve the right to charge and collect fees for **broken appointments** – (appointments that are cancelled or broken without 48 hours advance notice). There will be a charge of **$50.00** per appointment cancelled without a 48 hour notice. Appointments are reserved exclusively for you. In an effort to care for patients in a timely manner, we may offer to move your appointment to an earlier date/time if openings arise.

A Returned Check Fee, Closed Account Fee or Frozen Account Fee of $35.00 will be added to your account balance and is collectible. This must be resolved before proceeding with further treatment regarding this account.

Delinquent Accounts must be resolved prior to scheduling further appointments. We reserve the right to charge collection fees, $10.00 for any certified mail sent to you, attorney fees and all court fees to accounts forwarded from our office.

Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment. We offer CareCredit up to 6 months interest free. For extended financing terms, **you must apply for CareCredit prior to your treatment if you wish to use it.**

I have read and understand this financial policy.

_____

Printed Patient's Name

_____ _____

Patient's Signature (or Legal Guardian if applicable) Date

MEDEMAENDODONTICS

Brent A. Medema, D.D.S. – Specialist in Endodontics
Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known 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 acknowledgment, 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 entity's functions; a claim for payment of fees; a third party payers examination of our records; a court order as part of a criminal investigation, an identification of a dead body; a licensing investigation; or a child abuse/neglect 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 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 coordination your treatment.

Patient Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

Please sign this form under the following statement 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.

Printed Patient's Name _____ Patient's Signature (Guardian if under 18 years) _____ Date _____

FOR OFFICE USE ONLY

If the patient refused to sign please fill out the following.

The following circumstances prohibited the patient from signing the Acknowledgment:

_____

Office Personnel's Printed Name _____ Office Personnel's Signature _____ Date _____

Patient Consent

Please sign this form under the following statement to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your discourse of my information, which you deem necessary in connection with my treatment. I understand such disclosures may not be of the type listed above.

Printed Patient's Name _____ Patient's Signature (Guardian if under 18 years) _____ Date _____

MEDEMAENDODONTICS

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 5/5/2009, and will remain in effect until we replace 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 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 operations. 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.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any 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 your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment 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 look at or get copies of your health information with limited exceptions. If you 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 this 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 may charge you a nominal fee for each page, and a nominal fee per hour of staff time to copy your health information, and postage if you want the copies mailed to you. If you request and alternate 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 restrictions, but if we do, we will abide by our agreement (expect in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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

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 your 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 with the U.S. Department of Health and Human Services.

Contact Officer: Brent A. Medema, D.D.S
Telephone: (616) 891-1400 Fax: (616) 275-1125
E-mail: brent@medemaendo.com
Address: 9039 N. Rodgers Ct. Ste 4, Caledonia, MI 4316