Richard Oppenlander, D.D.S.

info@MichiganAdvancedDentistry.com MichiganAdvancedDentistry.com

8191 Moorsbridge Rd, Suite C • Portage, MI 49024 (269)327-9332

Welcome to Our Office

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

How may we contact you for appointment reminders?

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text ☐ Email

Whom may we thank for referring you to our practice?

_____

_____

May we use your name in thanking this person? ◯ Yes ◯ No

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or you are the parent/guardian of the patient.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ _____ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ * **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *PREMEDICATE
- ☐ Allergy-Amoxicillin
- ☐ Allergy-Anesthetic
- ☐ Allergy-Aspirin
- ☐ Allergy-Augmentin
- ☐ Allergy-Ceclor
- ☐ Allergy-Clindamycin
- ☐ Allergy-Codeine
- ☐ Allergy-Epinephrine
- ☐ Allergy-Erythromycin
- ☐ Allergy-Iodine
- ☐ Allergy-Latex
- ☐ Allergy-Metals
- ☐ Allergy-Milk
- ☐ Allergy-Other Meds
- ☐ Allergy-Penicillin
- ☐ Allergy-Sulfa
- ☐ Allergy:Food/ColorAd
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Anxiety/Nervousness
- ☐ Artherosclerosis
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Auto Immune Disorder
- ☐ Bisphosphonate Meds
- ☐ Bleeding Problems
- ☐ Blood Thinner
- ☐ Blood Transfusion
- ☐ Bruise/Bleed Easily
- ☐ Cancer
- ☐ Canker/Cold Sores
- ☐ Celiac Disease
- ☐ Chemotherapy
- ☐ Congenital Disorder
- ☐ Coronary Stent
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fever Blister/Herpes
- ☐ GERD
- ☐ GI Problems
- ☐ Glaucoma
- ☐ Gluten Intolerance
- ☐ Growths
- ☐ HIV+/AIDS
- ☐ Hashimotos Disease
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart RhythmAbnormal
- ☐ Heart Surgery
- ☐ Heart Valve Repl.
- ☐ HeartDisease/Cond.
- ☐ Hepatitis A or B
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Kidney Disease
- ☐ Lactose Intolerance
- ☐ Liver Dis./Jaundice
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral ValveProlapse
- ☐ Mouth Ulcers
- ☐ Osteoporosis
- ☐ Other - See Notes
- ☐ Percocet
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Seizures/Convulsions
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sinusitis
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Swelling Limbs
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Venereal Disease

If any conditions or alerts selected above need further clarification or if there are any allergies or conditions not noted, please list and/or describe below:

_____

_____

_____

Describe any current medical treatment, impending surgery, or other treatment.

_____

_____

_____

Females:
Please indicate if any of the following apply:

☐ Taking birth control ☐ Nursing

If pregnant, please indicate your Due Date: _____

Do you take antibiotic premedication for your dental visits? * ◯ Yes ◯ No

Pre-Med (required prescription)

Name of pharmacy and pharmacy phone number: *

Name of your physician and physician phone number: *

Most recent physical exam?

Have you opted out of recommended vaccinations? If yes, please list below:

Have you had a vaccination for Covid 19? ◯ Yes ◯ No

If yes, when? Which vaccine?

Are you currently taking any medications, drugs, pills, herbal remedies, supplements, including regular dosages of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Medications/Supplements/Herbal Remedies:

Please check all that apply:

◯ Tobacco use
◯ Alcohol addiction: current or recovering
◯ Smoking or Vaping habit
◯ Drug addiction: current or recovering
◯ Marijuana use
◯ Opioid addiction: current or recovering

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Dental Information

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam: _____

Date of most recent dental x-rays: _____

Is there anything about the appearance of your smile that you would like to change?

_____

_____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Do you have any specific dental concerns:

_____

_____

_____

Have you ever experienced any of the following problems in your jaw? Please check all that apply:

☐ Clicking ☐ Difficulty chewing ☐ Difficulty in opening or closing ☐ Pain (joint, ear, side of face, neck)

Do you have a bitesplint? ◯ Yes ◯ No

Do you have Airway Problems? (enlarged tonsils/adenoids, sleep apnea) If yes please explain.

_____

_____

Are you happy with the appearance of your smile? If no, please explain.

_____

_____

_____

Check all that apply:

- [ ] Had complications from past dental treatment
- [ ] Had trouble getting numb
- [ ] Had any reactions to local anesthetic
- [ ] Had/have braces, orthodontic treatment
- [ ] You experience dry mouth
- [ ] Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- [ ] Food gets trapped between any teeth
- [ ] Have you ever whitened or bleached your teeth
- [ ] Have you experienced pain, popping and/or clicking of your jaw joint
- [ ] Have ringing in ears (Tinnitus)
- [ ] You have difficulty chewing
- [ ] You clench or grind your teeth(Bruxism)
- [ ] You wear or have worn a bite appliance
- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury)
- [ ] Experienced a burning sensation in your mouth
- [ ] You snore/wake up frequently during the night
- [ ] You feel unnecessarily tired during the day
- [ ] You experience headaches or migraines
- [ ] Have any area of your face, head or neck that is tender to touch
- [ ] Had/have any swelling in or around face, head or neck that hasn't healed readily within a few days
- [ ] You experience morning congestion

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ * **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

HIPAA Acknowledgement

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 payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of our 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 coordinating your treatment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Medical Information Release

Dear Patients,

With the new health care regulations in effect, we now need to have documentation as to whom you may want to have access to your medical information. This includes, but is not limited to health and account information. We need you to supply us with written consent for those you wish to have access. Once you sign this form, it will become part of your medical record. If you need to add or delete anyone from this list, you must notify us in writing of the change. Anyone seeking information on your behalf will have to be on this list or we will not release any information to them. This includes spouses, children, and caregivers of any sort. Thank you for your understanding.

1. Authorized Person/Relationship

_____

_____

2. Authorized Person/Relationship

_____

_____

3. Authorized Person/Relationship

_____

_____

4. Authorized Person/Relationship

_____

_____

5. Authorized Person/Relationship

_____

_____

☐ * **By checking this box, I am giving permission to release information to the above named people.**

Name of patient, parent or guardian completing this form: *

☐ Self ☐ Parent ☐ Guardian ☐ Spouse ☐ Other

Signature _____ **Date** _____

Response Date: _____