Patient Registration and Medical History

(Please Print)

Date _____ **Home Phone** _____ **Cell Phone** _____

Name _____ **Nickname** _____

Address _____ **City** _____ **State** ____ **Zip** _____

Birthdate ____/____/____ **Please Circle One:** *Minor Single Married Widowed Separated Divorced*

If Student; School _____ **Grade** ____ **City** _____ **State** _____

Employer _____ **Work Phone** _____

Employer Address _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

Dental Insurance Company _____ **SS#** _____

Policy Holder _____ **Date of Birth** ____/____/_____

Policy Holder Employer _____ **Work Phone** _____

Member ID _____ **Group Number** _____

Other Dental Insurance _____

Member ID _____ **Group Number** _____ **Policy Holder** _____

Whom may we thank for referring you? _____

Email Address _____

Medical History

(Check all that apply)

❑ High Blood Pressure	❑ AIDS or HIV	❑ Fainting / Seizures	❑ Tuberculosis	❑ Heart Attack
❑ Thyroid Problem	❑ Hepatitis	❑ Radiation Therapy	❑ Rheumatic Fever	❑ Heart Disease
❑ Cardiac Pacemaker	❑ Glaucoma	❑ Joint Replacement	❑ Liver Disease	❑ Epilepsy
❑ Mitral Valve Prolapse	❑ Heart Problems	❑ Chest Pains	❑ Stomach Ulcers	❑ Angina
❑ Recent Weight Loss	❑ Frequently Tired	❑ Low Blood Pressure	❑ Kidney Disease	❑ Asthma
❑ Respiratory Problems	❑ Leukemia	❑ Emphysema	❑ Easily Winded	❑ STDs
❑ Diabetes	❑ Cancer	❑ Hay Fever / Allergies	❑ Stroke	❑ Arthritis
❑ Anemia	❑ Other _____			

Do you have any drug allergies or have you ever had an adverse reaction to any medication?

Circle One Yes *or* **No**

If yes, explain _____

Have you ever responded adversely to any medical or dental treatment? Yes *or* **No**

Are you under the care of a physician? Yes *or* **No For what?** _____

If patient is a child, what is her/her weight? _____

WOMEN: Do you suspect that you are pregnant? Yes *or* **No**

Are you Nursing? Yes *or* **No**

Please list any Medications you are taking at this time:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and passing of insurance information for benefits which I am entitled. I will not hold my dentist or any member of his / her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature _____ *Date* ____/____/____

Diane M. McLellan, D.D.S.

20211 Ecorse Road
Taylor, Michigan 48180
313.383.1125

OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies:

1. **Payment is due at the time of service unless arrangements have been made in advance.** We accept Cash and Checks. A fee of $15 will be charged for all returned check. (NSF)
2. Keep in mind that your insurance policy is basically a contract between you and your insurance policy company. As a service to you, we will file your insurance claim if you assign benefits to the doctor – in other words – you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for the payment. If we later receive a check from your insurer we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other dental plans to accept an assignment of benefits. We will bill them and you are required to pay the copayment, if any, at the time of your visit.
4. If you have no dental insurance our charges for your care are due at the time of service.
5. Not all insurance plans cover our services. In the event your insurance plan determines a services to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. Should the due amount go past the 30-day grace period, a service charge will be added to your account.
6. **We charge a fee of $25 for failed appointments for those not cancelled within 24 hours,** if appointment is not filled.
7. If your account is turned over to a collection agency, you will be responsible for fees they charge us to collect your balance.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____ / / _____

Signature of Patient or Guardian *Date*

_____

Please Print Name of Patient

Diane M. McLellan, D.D.S.

20211 Ecorse Road
Taylor, Michigan 48180
313.383.1125

SECTION A: THE PATIENT

Name: _____

Address: _____

Telephone: _____

Email: _____

Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____ , acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature _____ *Date* ____/____/____

A personal representative who signs this authorization on behalf of the individual must complete the following:

Personal Representative's Name: _____

Relationship to Individual _____

FOR OFFICE USE ONLY

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt

Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

Describe the reason why this individual would not sign this:

_____

_____

Attest that the above information is correct:

Signature _____ *Date* ____/____/____