



WELCOME TO OUR OFFICE

OUR COMMITMENT

We are committed to offering world-class dentistry in a warm, welcoming, calm environment. Our focus is on integrity and sincere concern for our patients and community.

We are dedicated to treating everyone like family while providing quality dental care using the latest technology. We understand your time is valuable so we make every effort to remain on time.

We believe our relationship with you needs to be open with clear communication. We will inform you of our dental recommendations and the related costs as soon as possible.

YOUR COMMITMENT

We want you to be comfortable with our team. If you have questions about finances, insurance, dental treatment or any concerns at all, please notify us and we will promptly address your questions or concerns.

Payment is due upon completion of services, unless prior arrangements have been made. Please note some or all services may not be covered by your insurance. If you change insurance companies, please let us know.

We understand circumstances may arise that require you to cancel your reservation. We ask that you notify us as soon as you can. If sufficient notice (2 business days) is not provided or multiple reservations are missed, your account could be charged a missed appointment fee. We asked that you make every effort to keep your reserved time.

We look forward to taking care of your oral health needs and we welcome you to our office!

I have read the above and understand my commitment.

Patient/Guardian: _____ Date _____



Shwedel Dental
FAMILY, COSMETIC & LASER DENTISTRY

CHILD REGISTRATION

(Please print clearly)

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____

Patient Name _____ Birthdate _____ Cell# _____

Address _____ Home# _____

City _____ State _____ Zip code _____ S.S.# _____

Parent/Guardian _____

Emergency Contact/ Relationship to person _____ Cell _____

Person responsible for account: _____

PRIMARY INFO:

Primary Insurers' Name _____ Cell# _____

Subscribers' Dental Ins _____ Group # _____ Birthdate _____

S.S. # _____ Alt ID# _____ DL# _____

Subscribers' Employer _____ Email _____

SECONDARY INFO:

Secondary Insurers' Name _____ Cell# _____

Secondary Dental Insurance _____ Group # _____ Birthdate _____

S.S. # _____ Alt ID# _____ DL# _____

Secondary Employer _____

Signature _____ **Date** _____



Shwedel Dental

FAMILY, COSMETIC & LASER DENTISTRY

Name _____ Date _____
Last First

Please tell us **ALL** the ways you heard about Shwedel Dental.
(Select all that apply)

____ Friend/Family *Name:* _____

____ Staff Member *Name:* _____

____ Other Dentist/Doctor *Name:* _____

____ Internet Search

____ Our Website

____ Insurance Co. Website

____ Postcard (Direct Mail)

____ Yellow Pages (phone book)

____ Taylor Today - Community Magazine

____ FaceBook

____ Sign

____ New Neighbor letter or postcard

____ Dentistry From the Heart

____ Fish & Loaves

____ Newspaper

____ Chamber of Commerce Event

____ Television Commercial

____ Other _____

COMMUNITY EVENTS

____ Turn Off the Violence

____ Taylor Fall Fest

____ Little League Baseball

____ Heritage Park Clean-Up

____ Taylor Summer Festival

____ Health Fair _____

____ Happy Soles 5K

____ Summit Academy Expo

____ Art Ambience

____ Farmers Market

____ Day Care Visit

____ Taylor Virtual Learning Acad.

____ Other Event _____



Shwedel Dental

FAMILY, COSMETIC & LASER DENTISTRY

25650 Goddard Rd., Suite A, Taylor, MI 48180

PATIENT NAME _____ REG# _____

Email address _____ Date of birth _____

HEALTH HISTORY FORM

Please **CIRCLE** the appropriate response next to each question below: Yes (Y), No (N), Don't Know (?)

MEDICAL HISTORY

Do you have or have you had any of the following:

1. Breathing problems?

- a. Asthma Y N ?
- b. Emphysema Y N ?
- c. Bronchitis Y N ?
- d. Tuberculosis Y N ?
- e. Shortness of breath Y N ?
- f. Other breathing problems Y N ?

Explain: _____

2. Heart or circulation problems?

- a. High blood pressure Y N ?
- b. Heart attack Y N ?
- c. Angina or chest pain Y N ?
- d. Irregular heart beat Y N ?
- e. Rheumatic fever Y N ?
- f. Heart murmur Y N ?
- g. Mitral valve prolapse Y N ?
- h. Damage to heart valves Y N ?
- i. Heart valve replacement Y N ?
- j. Pacemaker/other cardiac device Y N ?
- k. Congestive heart failure Y N ?
- l. Swollen ankles Y N ?
- m. Other heart or circulation problems Y N ?

Explain: _____

3. Kidney or urinary problems?

- a. Kidney disease Y N ?
- b. Dialysis Y N ?
- c. Frequent urination Y N ?
- d. Other kidney problems Y N ?

Explain: _____

4. Nervous system problems?

- a. Stroke or transitory ischemic attack Y N ?
- b. Fainting spells Y N ?
- c. Convulsions, seizures or epilepsy Y N ?
- d. Other nervous system problems Y N ?

Explain: _____

5. Head and neck problems?

- a. Nose or sinus problems Y N ?
- b. Swollen Glands Y N ?
- c. Oral cancer Y N ?
- d. Impairment of hearing, sight or speech Y N ?
- e. Frequent or severe headaches Y N ?
- f. Other head and neck problems Y N ?

Explain: _____

6. Hormone or gland problems?

- a. Thyroid disease Y N ?
(hypothyroidism, hyperthyroidism)
- b. Diabetes Y N ?
- c. Adrenal or pancreatic disease Y N ?
- d. Any other hormone/gland disease Y N ?

Explain: _____

7. Muscle, bone or skin problems?

- a. Arthritis Y N ?
- b. Osteoporosis Y N ?
- c. Artificial joint placement Y N ?
- d. Hives or skin rash Y N ?
- e. Skin cancer Y N ?
- f. Back problems Y N ?
- g. Other muscle, bone or skin disease Y N ?

Explain: _____

8. Stomach, liver or intestinal problems?

- a. Liver disease Y N ?
- b. Hepatitis Y N ?
- c. Acid reflux (GERD) Y N ?
- d. Ulcers Y N ?
- e. Other stomach, intestinal or liver problems Y N ?

Explain: _____

9. Behavioral/Sensory disorders or Autism? Y N ?

Explain: _____

EXAMINER'S COMMENTS _____

over please

10. Allergic reactions or other problems?

- a. Seasonal allergies Y N ?
- b. Allergy, reaction or intolerance to:
 - Penicillin Y N ?
 - Erythromycin Y N ?
 - Codeine Y N ?
 - Latex Y N ?
 - Local anesthetics Y N ?
 - Foods/flavoring Y N ?
 - Other substances Y N ?

Explain: _____

11. Blood or immune system problems?

- a. Cancer of any type Y N ?
- b. Organ or bone marrow transplant Y N ?
- c. Lupus Y N ?
- d. Multiple sclerosis Y N ?
- e. Anemia Y N ?
- f. Hemophilia Y N ?
- g. AIDS/HIV Y N ?
- h. Frequent nosebleeds, increased bruising or bleeding Y N ?
- i. Are you taking any blood thinners? Y N ?
- j. Have you had chemotherapy or radiation treatment? Y N ?
- k. Other problems with the blood or immune system? Y N ?

Explain: _____

12. What medications or other substances are you taking or have you taken in the past 2 months?

- a. Please list all prescription and non-prescription drugs including aspirin, birth control pills, herbal medications or other supplements. Write "none" if you are not taking any medications or other substances.

- b. Have you ever taken the drugs Fenfluramine (Fen-phen), Pondimin, or Dexfenfluramine (Redux)? Y N ?
- c. Have you taken or are you taking drugs to control bone loss (ie. Fosamax) Y N ?

13. Personal History

- a. Have you ever been hospitalized, had major surgery or been seriously hurt? Y N ?
If yes, what type and when _____
- b. Have you had or do you have any sexually transmitted diseases (syphilis, gonorrhea, herpes, etc.)? Y N ?
- c. Do you need any special accommodations for dental treatment? Y N ?
- d. Are you pregnant? Y N ?
- e. Have you ever used tobacco products? Y N ?
- f. Are you currently using tobacco products? Y N ?

What type and how often _____

- g. How many alcohol containing drinks do you consume a week? _____
- h. Do you use or have you used any recreational drugs? Y N ?
- i. Have you ever had a problem with alcohol or drugs? Y N ?
- j. Do you have mental health problems? Y N ?
- k. When was your last visit to a physician (medical doctor)? _____
- l. Do you have a physician (medical doctor)? Y N ?

If yes, please provide the Name, Address and Telephone _____

EXAMINER'S COMMENTS _____

DENTAL HISTORY

1. What is the reason for your dental visit? _____

2. Have you ever had any problems following dental treatment? Y N ?
If yes, explain _____
3. Have you ever had a bad or unusual reaction to local anesthetic? Y N ?
4. Have you ever had a severe injury to your face, teeth or jaws? Y N ?
5. Have you ever had surgery in your mouth or on your lips? Y N ?
6. Have you ever had periodontal treatment to your gums? Y N ?
7. Have you ever had orthodontic treatment to straighten your teeth? Y N ?
8. Have you ever had extraction (pulling) of any teeth? Y N ?
9. Have you ever had endodontics (root canals) on any teeth? Y N ?
10. Have you had any teeth replaced by a removable denture, fixed bridge or implant? Y N ?
11. Have you ever worn a bitesplint/nightguard? Y N ?
12. Have you had a recent toothache? Y N ?
13. Are your teeth sensitive to hot, cold or pressure? Y N ?
14. Do you have bleeding gums? Y N ?
15. Do you have trouble chewing? Y N ?
16. Do you clench or grind your teeth? Y N ?
17. Do you have difficulty opening your mouth as wide as you would like? Y N ?
18. Do your jaw joints or muscles hurt? Y N ?
19. Does your jaw click, pop, or lock when you chew? Y N ?
20. Do you experience dry mouth? Y N ?
21. Do you have sores in or around your mouth? Y N ?
22. Please circle the amount of sugar in your diet. small moderate high
23. When was the last time your teeth were cleaned at a dental office? _____
24. How often do you brush? _____
25. How often do you use dental floss? _____
26. Are you satisfied with the appearance of your teeth? Y N ?
If No, Why not? _____
27. What would keep you from continuing with necessary dental treatment? (please circle)
Fear Time Urgency Budget No Trust
28. What do you value most in regards to dental treatment? (please circle)
Cosmetic Function Comfort Longevity

EXAMINERS COMMENTS _____

I certify that to the best of my knowledge the above information is complete and accurate.

Patient signature _____ Date _____

If other than the patient, indicate relationship _____

Reviewed by Dr. _____

1st Review and update of questionnaire:

Changes _____

Patient signature _____ Date _____

If other than patient, indicate relationship _____

Update reviewed by Dr. _____

2nd Review and update of questionnaire:

Changes _____

Patient signature _____ Date _____

If other than patient, indicate relationship _____

Update reviewed by Dr. _____

3rd Review and update of questionnaire:

Changes _____

Patient signature _____ Date _____

If other than patient, indicate relationship _____

Update reviewed by Dr. _____

**The health history form should be updated at least every 6 months
and a new form must be filled out every 2 years.**

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization, in refusing we may not be allowed to process your insurance claims.

DATE: _____

This undersigned acknowledges the receipt of a copy of the currently effective Notice of Privacy Practices for this health care facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

Print your name

Sign your name

Legal Representative

Description of Authority

Your comments regarding Acknowledgments or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Sir Name Other _____

LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step-parents, grandparents and any care takers who can have access to your patient records):

Name: _____

Name: _____

Name: _____

Name: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENT, TREATMENTS & BILLING INFORMATION VIA:

Cell Phone Confirmation _____ Text Message to my Cell Phone _____

Home Phone Confirmation _____ Email Confirmation _____

Work Phone Confirmation _____ Any of the above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

Cell Phone Confirmation _____ Text Message to my Cell Phone _____

Home Phone Confirmation _____ Email Confirmation _____

Work Phone Confirmation _____ Any of the above

I AUTHORIZE SHWEDEL DENTAL TO USE MY PHOTO FOR SOCIAL MEDIA PURPOSES, DESIGNED FOR NEWS, INFORMATIONAL AND/OR ADVERTISING PURPOSES.

Signature _____

In signing this HIPPA Patient Acknowledgment Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPPA Omnibus Rule, provide you this information with your acknowledge and consent.

OFFICE USE ONLY

As privacy officer, I attempt to obtain the patient's (or representatives) signature on this acknowledgment but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient was unable to sign because _____
- Other (describe) _____

Signature of Privacy Officer