NEW PATIENT HISTORY AND INFORMATION

CONFIDENTIAL INFORMATION FOR OUR FILES

Knollwood Dental Care

Last Name: _____ **First Name:** _____ **Middle Initial:**_____

Date of Birth _____ **Drivers License Number:** _____

Social Security Number: _____**Email Address:**_____

Phone Number: Home:_____**Cell:**_____ **Work:** _____

Address:_____**City**_____ **State:**_____ **Zip Code:**_____

Referred to Knollwood By: _____

Your Employer: _____ **May we contact you there? ⑥ Yes ⑥ No**

Spouse's Name: _____ **Employer:** _____

Spouse's Work Phone: _____ **Number of Dependents:** _____

Person Financially Responsible for Dependents: _____

In Case of Emergency, Contact: _____**Phone** _____

Previous Dentist (Name / Address / Phone)**:** _____

Do you have any current x-rays at your previous office? □ **Yes** □ **No**

If yes, may we contact them to request copies to be sent to us? □ **Yes** □ **No**

Primary Dental Ins Company, including address:_____

Name of Insured: _____ **Group Name/Number:** _____

Social Security of Insured: _____ **Date of Birth of Insured:** _____

Employer of Insured Person: (Name / Phone Number)**:**_____

Secondary Dental Insurance Company (If Applicable)**:** _____

Name of Insured: _____ **Group Name/Number:** _____

Social Security of Insured: _____ **Date of Birth of Insured:** _____

I authorize my insurance benefits to be paid to Knollwood Dental Care, PC. I understand I am ultimately financially responsible for all services I receive including co-pays, deductibles and non-covered services. Payment is expected at time of treatment unless other arrangements have been made with the billing department. I understand my account will be assessed a monthly finance charge if my balance is carried longer than 30 days. I understand there will be a $35 fee for insufficient checks. If I fail to give 48 hours advance notice; I may be assessed a no-show fee equal to the value of the appointment I missed.

SIGNED: _____ **DATE:** _____

NEW PATIENT MEDICAL HISTORY
(CONFIDENTIAL INFORMATION FOR OUR FILES)

Knollwood Dental Care

PATIENTS NAME: _____ **DATE OF BIRTH:** _____

1. Are you under the care of a physician? ☐ No ☐ Yes Physician name:_____

   If yes, for what condition(s)_____ Physician Phone: _____

   City, St _____ , Zip _____

2. Are you currently taking any prescription or non-prescription drugs or medications? ☐ NO ☐ YES
   If yes; please list name, dosage and if taken daily, monthly or once a year _____

   _____

3. Have you ever taken any medication for Osteoporosis? ☐ NO ☐ YES If so please list name and

   date medication was taken_____

4. Do you take an aspirin daily? ☐ NO ☐ YES. Quantity? _____ How often? _____

5. Do you have any allergic (or adverse) reactions to any medication or substance? ☐ NO ☐ YES

   If Yes, please list here:_____

6. Have you ever had a reaction to epinephrine ☐ NO ☐ YES, Explain:_____

7. Have you been hospitalized in the last 5 yrs? ☐ NO ☐ YES for _____

8. Were you born with a heart condition? ☐ NO ☐ YES, Explain:_____

9. Do you have an artificial heart valve ☐ NO ☐ YES

10. Have you ever had Infective Endocarditis? ☐ NO ☐ YES

11. Do you have a prosthesis such as a knee or hip replacement? ☐ NO ☐ YES. Please specify type and

    date of your prosthesis _____

12. Do you have Alzheimer's Disease or Dementia? ☐ NO ☐ YES

    _____

13. Do you have a personal history of any of the following? Circle Yes or No

Heart Surgery or Disease	Y	N	Thyroid Trouble	Y	N	Sinus Problems	Y	N
High Blood Pressure	Y	N	Tumors	Y	N	Psychiatric Care	Y	N
Diabetes	Y	N	Cancer	Y	N	Fainting Spells	Y	N
Rheumatic Fever	Y	N	Radiation/Chemotherapy	Y	N	Anemia	Y	N
Asthma	Y	N	Latex Sensitivity	Y	N	Hemophilia	Y	N
Ulcers/Gastro Problems	Y	N	Hepatitis A	Y	N	Eye or Ear Problems	Y	N
Tuberculosis	Y	N	Hepatitis B	Y	N	Arthritis	Y	N
Kidney or Liver Involvement	Y	N	A.I.D.S.	Y	N	Epilepsy	Y	N
Blood Disease	Y	N	H.I.V. Positive	Y	N	Special Needs _____	Y	N

14. Are you subject to profuse bleeding: ☐ NO ☐ YES

15. Women Only: Are you pregnant? ☐ NO ☐ YES, Due Date _____

SIGNED:_____ **DATE:** _____

Knollwood Dental Care

35409 Schoenherr Rd | Sterling Heights MI, 48312 | 586-268-1400

Written Financial Policy

Thank you for choosing Knollwood Dental Care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, Discover Card or American Express

- NO INTEREST[1] Payment Plans[2] from CareCredit
    - Allow you to pay over time with NO INTEREST[1]
    - Convenient, low monthly payment plans[2] also available
    - No annual fees or pre-payment penalties

Please note:

We require payment in full upon your first visit until you have become an established patient of the practice.

Knollwood Dental Care requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3] However, you are ultimately responsible for all charges and what insurance does not cover.

A statement fee may be charged on all accounts over 30 days. The minimum monthly fee is $1.00.

A fee of $50 is charged for patients who miss or cancel more than 1 time in a calendar year without 48-hour notice.

Knollwood Dental Care charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

KNOLLWOOD DENTAL CARE

Acknowledgement of Receipt of Notice of Privacy Practices

"You May Refuse to Sign This Acknowledgement"

I have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Patient Name)

_____
(Signature of Patient, Parent, or Guardian)

_____
(Date)

In addition to the Notice of Privacy Practices, you may also disclose my information to:

Name: _____ **Phone Number:** _____
Name: _____ **Phone Number:** _____
Name: _____ **Phone Number:** _____
Name: _____ **Phone Number:** _____

**** For Office Use Only ****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communications barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (Please specify)

_____
_____
_____

KNOLLWOOD DENTAL CARE

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 8/01/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; or Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National 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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.