FRUITPORT FAMILY DENTISTRY
Donna L. Rick, D.D.S.
Chelsea L. Klipfel, D.D.S., P.L.L.C.
40 Beech St.
Fruitport, MI 49415
231-865-6141

Welcome to our practice! It is the intention of this office to provide for your dental health as thoroughly and as efficiently as possible. We believe service to our patients is at its best when there is a complete mutual understanding and cooperation. Therefore, we would like to acquaint you with the customary sequence of procedures for the new patient in our practice.

1. The initial appointment is spent conducting a thorough examination. This includes a complete health history, a visual examination of the mouth tissue and teeth, and the necessary x-rays.

2. From our study of the x-rays and the clinical findings, we will diagnose your case based on the conditions present in your mouth and recommend proper treatment.

3. When the method of treatment is decided upon, we will either proceed or arrange future appointments so your dentistry can be completed as efficiently and as quickly as possible. Fees for the recommended services are outlined and payment or insurance co-payment is expected on the date of service unless arrangements are made in advance.

4. The treatment room will be reserved for you at the time you specify as most convenient. If for some unforeseen reason you find it impossible to keep a scheduled appointment, please let us know at least 24 hours in advance so another patient may use the time that had been reserved for you. <u>There is a $45.00 charge for short notice cancellations or broken appointments. No subsequent appointments will be scheduled until the fee has been paid.</u>

5. Please fill out the enclosed health and registration form with an ink pen and bring it with you to your appointment. NOTE: <u>If you have an artificial heart valve or an artificial joint replacement please contact your physician prior to your appointment as you may need an antibiotic in order to receive any dental</u> treatment.

Sincerely,

Dr. Donna L. Rick
Dr. Chelsea L. Klipfel

ADULT

PATIENT REGISTRATION

1. PATIENT INFORMATION *Date:*

Last name: _____ First name: _____ Middle name: _____

Address: _____ City/State/Zip_____

E-mail address: _____ Birth date: _____ Age: _____ Sex: M or F

SS#: _____ **Driver's license #:** _____

Place of employment:_____

CIRCLE ONE: Married Widowed Single Separated Divorced Minor

Spouse's name (if married): _____ Spouse's place of employment: _____

2. PHONE NUMBERS

Home (_____)_____ Work (_____)_____ Cell phone (_____)_____ Ext _____ **May we call you at work?_____**

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT (Name someone who does not live in your household.) Name: _____

Relationship: _____ Home phone (_____)_____ Work (_____)_____

3. RESPONSIBLE PARTY INFORMATION - FILL OUT ONLY IF SOMEONE OTHER THAN PATIENT

Last name: _____ First name: _____ Middle name: _____

Address: _____City/State/Zip: _____

SS#: _____ E-mail address: _____ Birth date: _____ Age: _____ Sex: M or F

Driver's license #: _____ Home phone: (_____)_____ Work (_____)_____

4. INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Name of insured: _____
Insured SS#: _____
Employer: _____
Address: _____
Phone: _____
City/State/Zip: _____

Relationship to patient: self spouse child other_____
Insured Birth date: _____
Ins. Company: _____
Address: _____
Phone: _____
City/State/Zip: _____

SECONDARY INSURANCE INFORMATION

Name of insured: _____
Insured SS#: _____
Employer: _____
Address: _____
Phone: _____
City/State/Zip: _____

Relationship to patient: self spouse child other_____
Insured Birth date: _____
Ins. Company: _____
Address: _____
Phone: _____
City/State/Zip: _____

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ADULT

ASSIGNMENT AND RELEASE

I understand that payment is due in full the day services are rendered unless previous arrangements are made. A monthly finance charge or statement fee of $5.00 may be added if my balance goes beyond 30 days. I understand also that a fee may be charged to my account if my appointment is broken without 24 hours notice.

I agree the above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Donna L. Rick all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____

Signature of patient, parent, guardian or personal representative

_____

Please print name of patient, parent, guardian or personal representative

_____

Date Relationship to patient

5. DENTAL HISTORY

Whom may we thank for referring you?_____

Reason for today's visit_____

Former Dentist_____

City/State_____

Date of last visit_____

Date of last dental x-rays_____

Circle "yes" or "no" to indicate if you have had any of the following:

Yes	No	Bad breath	Yes	No	Loose teeth or broken fillings
Yes	No	Bleeding gums	Yes	No	Mouth breathing
Yes	No	Blisters on lips or mouth	Yes	No	Mouth pain when brushing
Yes	No	Burning sensation on tongue	Yes	No	Orthodontic treatment
Yes	No	Chew on one side of mouth	Yes	No	Pain around ear
Yes	No	Cigarette, pipe or cigar smoking	Yes	No	Periodontal treatment
Yes	No	Clicking or popping jaw	Yes	No	Sensitivity to cold
Yes	No	Dry mouth	Yes	No	Sensitivity to heat
Yes	No	Fingernail biting	Yes	No	Sensitivity to sweets
Yes	No	Food collection between teeth	Yes	No	Sensitivity when biting
Yes	No	Grinding teeth	Yes	No	Sores or growths in mouth
Yes	No	Gums swollen or tender			
Yes	No	Jaw pain or tiredness	How often do you floss? _____		
Yes	No	Lip or cheek biting	How often do you brush? _____		

Is there any problem not listed that you would like us to know about?_____

CHILD

WELCOME

We are pleased to welcome you and your child to our practice.
Please take a few minutes to fill out this form completely. If you have any questions, we'll be glad to help you.
We look forward to working with you in maintaining your child's dental health.

Patient Information

Date ___/___/____ Phone (____)_____

Name of Minor/Child _____
First name Middle Initial Last name

Sex: M or F Age_____ Birth date ___/___/____ Nickname _____ Hobbies _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

In the event that you are not present with your child at their dental appointment, do you authorize Dr. Donna Rick to do the recommended treatment? YES NO If you marked NO, you must be present at all appointments.

Responsible Party Information

Father's/Guardian's Name_____
Address (if different from patient's) _____
_____
Home phone_____ Work phone _____
Employer _____
SS# ____-____-_____ Birth date ____/____/_____

Mother's/Guardian's Name _____
Address (if different from patient's) _____
_____
Home phone_____ Work phone _____
Employer _____
SS# ____-____-_____ Birth date ____/____/_____

Insurance Information

Do you have dental insurance for this child? Yes No
Insured's Name _____
Insured's SS# ___-___-___ Birth date ___/___/___
Employer_____
Ins. Co. _____
Phone # _____
Address _____
_____
Group # _____ Policy # _____

Do you have secondary coverage for this child? Yes No
Subscriber Name _____
Insured's SS# ___-___-___ Birth date ___/___/___
Employer_____
Ins. Co. _____
Phone # _____
Address _____
_____
Group # _____ Policy # _____

Emergency Contact

In the event of an emergency, whom should we contact?
Name _____Relationship _____ Phone _____
Name _____Relationship _____ Phone _____

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CHILD

ASSIGNMENT AND RELEASE

I understand that payment is due in full the day services are rendered unless previous arrangements are made. A monthly finance charge or statement fee of $5.00 may be added if my balance goes beyond 30 days. I understand also that a fee may be charged to my account if my appointment is broken without 24 hours notice.

I agree the above-named dentist may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Donna L. Rick all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____

Signature of patient, parent, guardian or personal representative

_____

Please print name of patient, parent, guardian or personal representative

_____

Date Relationship to patient

Dental Information

Whom may we thank for referring you?_____

Reason for today's visit_____

Former Dentist_____

City/State_____

Date of last visit_____

Date of last dental x-rays_____

Circle "yes" or "no" to indicate if you have had any of the following:

Yes	No	Bad breath	Yes	No	Loose teeth or broken fillings
Yes	No	Bleeding gums	Yes	No	Mouth breathing
Yes	No	Blisters on lips or mouth	Yes	No	Mouth pain when brushing
Yes	No	Chew on one side of mouth	Yes	No	Orthodontic treatment
Yes	No	Cigarette, pipe or cigar smoking	Yes	No	Pacifier use
Yes	No	Clicking or popping jaw	Yes	No	Pain around ear
Yes	No	Fingernail biting	Yes	No	Sensitivity to cold or heat
Yes	No	Fluoride: Taken in what form? _____	Yes	No	Sensitivity to sweets
Yes	No	Food collection between teeth	Yes	No	Sensitivity to when biting
Yes	No	Grinding teeth	Yes	No	Sleeps with bottle
Yes	No	Gums swollen or tender	Yes	No	Sores or growths in mouth
Yes	No	Injuries to mouth, teeth or head?	Yes	No	Thumb sucking
Yes	No	Jaw pain or tiredness	Yes	No	Unhappy dental experiences
Yes	No	Lip or cheek biting			

How often do you floss? _____

How often do you brush? _____

Is there any problem not listed that you would like us to know about? _____

Time 1:22 PM

DONNA L. RICK, D.D.S.

Date 11/9/2017

Medical History (Updated)

Patient Name: Birth Date: Date Created:

Are you taking any medications? ◯ Yes ◯ No If yes

Have you had any surgeries since your last visit? ◯ Yes ◯ No If yes

Are you under the care of a physician? ◯ Yes ◯ No If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ On birth control?

Are you allergic to any of the following?

☐ Aspirin	☐ Iodine	☐ Local Anesthetics	☐ Penicillin
☐ Codeine	☐ Latex	☐ Peanuts	☐ Sulfa Drugs
☐ Food	☐ Other		

Do you have, or have you had, any of the following?

Acid Reflux ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Hearing Problems ◯ Yes ◯ No	Pacemaker ◯ Yes ◯ No
ADD/ADHD ◯ Yes ◯ No	Chronic Fatigue Syndrome ◯ Yes ◯ No	Heart Attack ◯ Yes ◯ No	Radiation Therapy ◯ Yes ◯ No
AIDs/HIV ◯ Yes ◯ No	Circulatory Problems ◯ Yes ◯ No	Heart Problems ◯ Yes ◯ No	Respiratory Disease ◯ Yes ◯ No
Alzheimer's ◯ Yes ◯ No	Congenital Heart Lesions ◯ Yes ◯ No	Hepatitis: A ◯ Yes ◯ No	Seizures ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Cough/Persistent/Bloody ◯ Yes ◯ No	Hepatitis: B ◯ Yes ◯ No	Shortness of Breath ◯ Yes ◯ No
Anxiety ◯ Yes ◯ No	Defibrillator ◯ Yes ◯ No	Hepatitis: C ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Arthritis/Rheumatism ◯ Yes ◯ No	Depression ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Sleep Apnea ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Diabetes: Type I ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Snoring ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Diabetes: Type II ◯ Yes ◯ No	Kidney Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Autism ◯ Yes ◯ No	Eating Disorder ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swollen Feet/Ankles ◯ Yes ◯ No
Back Problems ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Problems ◯ Yes ◯ No
Bleeding Abnormality ◯ Yes ◯ No	Epilepsy ◯ Yes ◯ No	Lupus ◯ Yes ◯ No	Tobacco Use: Chew ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Fainting/Dizziness ◯ Yes ◯ No	Multiple Sclerosis ◯ Yes ◯ No	Tobacco Use: Smoking ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Fibromyalgia ◯ Yes ◯ No	Nervous Problems ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemical Dependency ◯ Yes ◯ No	Headaches/Migraines ◯ Yes ◯ No	Organ Transplant ◯ Yes ◯ No	Tumors on Head/Neck ◯ Yes ◯ No

If you said yes to any of the above, please explain: ◯ Yes ◯ No If yes

Other: ◯ Yes ◯ No If yes

Dental History

Bad Breath	◯ Yes ◯ No
Bleeding Gums	◯ Yes ◯ No
Clenching/Grinding Teeth	◯ Yes ◯ No
Jaw Clicking/Popping	◯ Yes ◯ No
Dry Mouth	◯ Yes ◯ No
Gums Swollen/Tender	◯ Yes ◯ No
History of Gum Disease	◯ Yes ◯ No
Sensitivity to Hot/Cold	◯ Yes ◯ No
Sensitivity to Sweets	◯ Yes ◯ No

Former Dentist and Date of Last Visit: ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

DONNA L. RICK, D.D.S., P.C.
CHELSEA L. KLIPFEL, D.D.DS., P.L.L.C
40 E. BEECH STREET
FRUITPORT, MI 49415
231-865-6141

PATIENT OFFICE POLICY EFFECTIVE 1/4/2016

We would like to thank you for choosing us to be your dental care provider. While we appreciate our patients and their consideration in keeping and showing up on time for their appointments, we have had some issues arise and we must now enforce the following:

There is a $45.00 missed or cancelled appointment fee if at least 24 hours is not given. We realize there are times that unforeseen circumstances cannot be avoided and we will consider these circumstances on an individual basis.

We require payment at the time of service, which includes: payment in full if no insurance and/or co-payments estimated with insurance. You are also responsible for any balance that your insurance does not pay.

There will be a 1.5 monthly (18%APR) or a $5.00 finance charged, whichever is greater on any account that is overdue 30 days or more.

Any patient who has had an account turned over for collection/court will be dismissed from the practice, even if all past due balances have been paid. A release can be signed and we will be happy to send records to a new dentist of choice.

While many insurance companies are covering bitewing x-rays every 2 years, it is recommended that bitewing x-rays be taken yearly and not doing so may result in failure to diagnose decay between your teeth. Dr Rick requires you not go more than 2 years for bitewings. A FMX/Panorex will be taken every 5-7 years to see the mouth in its entirety.

I understand I am responsible for any dental insurance deductible, co-insurance and any amount not paid by insurance. If this account is delinquent, I agree to pay all expenses including, but not limited to court filing and serving fees or any attorney fees incurred by Dr. Donna Rick in collection of this account.

There will be a $35.00 charge for any check returned due to non-sufficient funds available.

Thank you for your cooperation.

Signature of responsible party_____

Date of signature_____

All members listed on account_____

_____

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/LIMITED AUTHORIZATION RELEASE AND FORM

You may refuse to sign this acknowledgement & authorization. In refusing we will not file insurance claims and payment must be made upfront. No credit will be allowed.

Date:_____

The undersigned acknowledges 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.

_____ _____
Please print name of patient Please sign Patient/Guardian of Patient

_____ _____
Legal Representative/Guardian Relationship of Legal Representative

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step-parents, grandparents and any other care takers who can have access to this patient's records):

NAME:_____ RELATIONSHIP_____

NAME:_____ RELATIONSHIP_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO, **CONFIRM MY APPOINTMENTS TREATMENT AND BILLING INFORMATION** VIA:

___Cell Phone Confirmation _____
___Home Phone Confirmation _____
___Work Phone Confirmation _____
___Email Address _____

In signing this HIPAA Patient Acknowledgement 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 the current HIPAA Omnibus Rule, provide you this information with your acknowledgement and consent.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representative) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign because _____

Other (please describe) _____

Signature of Privacy Officer _____