PATIENT REGISTRATION FORM

NAME:_____ BIRTHDATE:_____

ADDRESS:_____ CITY, STATE, ZIP:_____

HOME PHONE:_____CELL:_____ WORK:_____

(please circle the best number to confirm your appointments)

Email Address (optional):_____

SSN:_____ Sex: F M Marital Status S M D W

Are you a full time student: Y N School Attending:_____

In case of an emergency, please notify:

Name:_____ Phone #:_____Relationship to Patient:_____

INSURANCE AND POLICY HOLDER INFORMATION

PRIMARY Insurance Company:_____ Employer:_____

Policy Holder:_____ Date of Birth:_____ Contract#(SSN):_____Group#:_____

SECONDARY Insurance Company:_____Employer:_____

Policy Holder:_____ Date of Birth:_____ Contract#(SSN):_____Group#:_____

Person responsible for this account:_____ Relationship to Patient:_____

How did you hear about us? Referral_____ Direct Mail Website Internet Sign

(please circle all that apply) (name of referral)

Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)

I, _____have been given the opportunity to read a copy of this office's Notice of Privacy Practices.

Name:_____

Signature:_____

Date:_____

Donald J. Kiss, D.D.S. , P.L.L.C.
42927 W. 7 Mile Road Northville, MI 48167 (248)348-7997 Fax: (248)348-0119

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ Date of Last Exam_____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Y N
If yes, please explain: _____

Have you taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Y N

What, if any, medications (including non-prescription medication) are you taking?_____

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

High Blood Pressure	_____	Heart Disease	_____	Chest Pains	_____
Heart Attack	_____	Cardiact Pacemaker	_____	Easily Winded	_____
Rheumatic Fever	_____	Heart Murmur	_____	Stroke	_____
Swollen Ankles	_____	Angina	_____	Hay Fever/Allergies	_____
Fainting/Seizures	_____	Frequently Tired	_____	Tuberculosis	_____
Asthma	_____	Anemia	_____	Radiation Therapy	_____
Anxiety	_____	Emphysema	_____	Cglaucoma	_____
Epilepsy/Convulsions	_____	Cancer	_____	Recent Weight Loss	_____
Leukemia	_____	Arthritis	_____	Liver Disease	_____
Diabetes	_____	Hepatitis/Jaundice	_____	Respiratory Problems	_____
AIDS or HIV Infection	_____	Sexually Transmitted Disease	_____	Mitral Valve Prolapse	_____
Thyroid Problems	_____	Stomach problems/Ulcers	_____	Joint Replacement	_____

Are you allergic to or have had any reactions to the following:

Local Anesthetics (e.g. Novocain)	_____	Any Metals (mercury, nickel)	_____
Penicillin or other antibiotics	_____	Latex Rubber	_____
Sulfa Drugs	_____	Sedatives	_____
Barbituates	_____	Iodine	_____
Aspirin	_____	Other	_____

Women Only: Are you pregnant? Y N Are you nursing? Y N

DENTAL HISTORY
Name of Previous Dentist: _____ Date of Last Oral Exam:_____

Do your gums bleed while brushing or flossing?	_____	Do you have frequent headaches?	_____
Are your teeth sensitive to hot or clod?	_____	Do you clench or grind your teeth?	_____
Do you feel pain to any of your teeth?	_____	Do you bite your lips or cheeks frequently?	_____
Do you have sores or lumps in or near mouth?	_____	Have you ever had difficult extractions?	_____
Have you had head, neck or jaw injuries?	_____	Do you wear dentures/partials?	_____
Have you had orthodontic treatment?	_____	Do you like your smile?	_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous. I authorize my insurance company to pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents

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_____
(please sign)

WRITTEN FINANCIAL POLICY

Thank you for choosing Donald J. Kiss, D.D.S.. 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 as possible by offering several payment options.

PAYMENT OPTIONS

- Cash, check, Visa, Mastercard, and Discover
- We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with case prior to completion of care.
- Convenient monthly payment plans from CareCredit

Please note:

Dr. Kiss requires payment at the time treatment is provided

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment.

A fee of $50.00 is charged for patients who miss or cancel more than 2 times in a calendar year without 48 hour notice.

Donald J. Kiss, D.D.S. charges $25.oo for returned checks.

If we do not receive payment from your insurance carrier for treatment provided, you will be responsible for payment

_____

Patient, Parent or Gaurdian Signature Print Date

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