TIME 04:30 PM DATE 6/7/2018

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Sheryl A. Pomerance, DDS

2018 HEALTH HISTORY

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Name/Telephone:	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No	If yes	
Do you use tobacco? If yes, how much?	Yes No		
Do you chew gum?	Yes No		
Do you need to pre-med?	Yes No		
Have you ever had a sleep study? If so where?	Yes No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	Yes No	If yes	
Other?	☐	If yes	

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No	Obstructive Sleep Apnea	Yes No	Peanut allergy	Yes No	Wear an occlusal guard	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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:_____

Medical Evaluation

Oral Cancer/Airway Management

Today's Date:_____

Patient Name:_____ Date of Birth:_____

Email Address:_____

Primary Medical Provider:_____ Phone:_____

Other Medical Provider(s):_____

Oral Cancer Evaluation

1. Have you ever been diagnosed or have a family history of Oral Cancer?	☐ YES	☐ NO
2. Have you ever been diagnosed or have a family history of HPV?	☐ YES	☐ NO
3. Do you currently use any tobacco products, or have used them in the past?	☐ YES	☐ NO
4. Do you use e-cigarettes or do you use vapor devices?	☐ YES	☐ NO
5. Do you regularly consume alcoholic beverages?	☐ YES	☐ NO

Medical History / Review of Systems

☐ **Morning Headaches**	☐ **Heart Disease**	☐ **Heart Failure**	☐ **Diabetes**	☐ **Insomnia**
☐ **Frequent Urination at Night**	☐ **ADD/ADHD**	☐ **Renal Failure**	☐ **Dry Mouth**	☐ **Depression**
☐ **Jaw Discomfort**	☐ **Chronic Pain**	☐ **Low Testosterone**	☐ **Memory Loss**	☐ **Snoring**
☐ **Grinding Teeth (Bruxism)**	☐ **Restless Legs (RLS)**	☐ **Atrial Fibrillation**	☐ **Night Sweats**	☐ **COPD**
☐ **Fatigue/Hypersomnia** (excessive daytime sleepiness)	☐ **Restless Sleep**	☐ **Obesity/Overweight**	☐ **Hypertension** (high blood pressure)	☐ **GERD** (acid reflux)

OSA / Airway Evaluation

1. Do you snore *or* have been told that you snore?	☐ YES	☐ NO	☐ NOT SURE
2. Do you often feel tired, fatigued, or sleepy during the daytime?	☐ YES	☐ NO	☐ NOT SURE
3. Has anyone observed you stop breathing or gasping for air during your sleep?	☐ YES	☐ NO	☐ NOT SURE
4. Do you have or are you being treated for high blood pressure or GERD (acid reflux)?	☐ YES	☐ NO	☐ NOT SURE

Epworth Sleepiness Scale	**Never doze off**	**Slight chance of dozing**	**Moderate chance of dozing**	**High Chance of dozing**
1. Do you get sleepy, or doze off, while sitting and reading?	0 ☐	1 ☐	2 ☐	3 ☐
2. Do you get sleepy, or doze off, while watching TV?	0 ☐	1 ☐	2 ☐	3 ☐
3. While sitting or inactive in a public place?	0 ☐	1 ☐	2 ☐	3 ☐
4. As a passenger in a car for an hour without a break?	0 ☐	1 ☐	2 ☐	3 ☐
5. Lying down to rest in the afternoon?	0 ☐	1 ☐	2 ☐	3 ☐
6. Sitting and talking to someone?	0 ☐	1 ☐	2 ☐	3 ☐
7. Sitting quietly after lunch without alcohol?	0 ☐	1 ☐	2 ☐	3 ☐
8. In a car, while stopped for a few minutes at a traffic light?	0 ☐	1 ☐	2 ☐	3 ☐
			Total Score	

Have you ever been diagnosed with sleep apnea/had a sleep study?	☐ YES	☐ NO
Are you currently using CPAP? (or any other apnea/snoring device)	☐ YES	☐ NO
Are you currently taking any sleeping aids (prescribed or OTC)?	☐ YES	☐ NO
Are you currently taking any prescribed pain medication?	☐ YES	☐ NO

Physical Evaluation- OFFICE USE ONLY

Gender:_____ **Height:**_____ **Weight:**_____ **BMI:**_____ **Blood Pressure:**_____

Neck Circumference:_____inches **Mallampati Score/Class:** 1 2 3 4 **Tonsil Size /Class:** 1 2 3 4

☐ **Enlarged/Scalloped Tongue** ☐ **Retruded Lower Jaw** ☐ **High Arching Hard Palate** ☐ **Enlarged Tonsils**

Provider Signature/Initials*_____ *To be filed for reference and review in patient's chart notes

Pomerance
INTEGRATIVE DENTAL CARE

Financial Agreement

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is the patient's responsibility to provide the correct insurance information at each visit. As a courtesy to you, we will file your dental insurance via electronic claims.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services. Any balance is your responsibility whether or not your insurance company pays any portion.

FULL PAYMENT is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES** are due at the time of service.

We accept the following forms of payment: **Cash, Check, Visa, Discover, MasterCard, AmEx.**

Pre-payment with Cash or check discount: We offer a 5% accounting courtesy for all services that are paid in full ***at the time of scheduling the appointment.***

We have also made arrangements with the Care Credit Company to provide payment plans. This allows you to complete your dental work without delay and make relatively small monthly payments. Applications are available and approval can be determined within ten minutes. For your convenience you can also apply online at www.carecredit.com

I have read, understand, and agree to the terms and conditions of this Financial Agreement.

Signature:_____ ***Date:***_____

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for your disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____
Patient Signature Patient Name (please print)

I am also signing for my minor children: _____
(please print names)

Date: _____

Patient Consent

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____
Patient Signature Patient Name (please print)

I am also signing for my minor children: _____
I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, caregiver)

_____
(please print names)

_____

Date: _____

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

_____ _____
Office Personnel (signature) Office Personnel (print name)

Date: _____

Pomerance
INTEGRATIVE DENTAL CARE

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Saline, Michigan 48176
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Fax: (734) 429-5752
www.PomeranceDentalCare.com

Dear Patients,

Our no-show/cancelation policy is as follows:

A cancelation or a no-show is documented in the event that the patient cancels or no-shows **without giving us two business days notice of their scheduled appointment.** Our office no-show cancelation fee is seventy five ($75.00) per hour.

We truly value our patient's time, just as we hope you value ours. Having said that, whenever a patient does not appear for a scheduled appointment, everyone is affected. You do not get the treatment needed and another patient loses out on the time that was allowed for you.

Please make every effort to provide to at least two business days notice if an appointment must be missed. We understand unexpected conflicts can occurs and that your lives are as busy as ours. We strive to work together with you to fit your schedule.

Thank you in advance for your understanding and cooperation,

Sheryl Pomerance, DDS & Staff

Agreed to and Acknowledged by:

Patient Name: _____

Patient Signature: _____

Date: _____