Cosmetic and Family Dentistry

(248) 624-0200

www.exceptionalsmiledds.com

PATIENT INFORMATION DATE:________________

NAME:____
DATE OF BIRTH:_______________E-MAIL:____________________________
ADDRESS:____
CITY:______________________ STATE:_____ ZIP:_____________________
HOME:_________________ WORK:______________ EMERG:_____________
MARITAL STATUS: SINGLE:___ MARRIED:___ DIVORCED:___ WIDOWED:___
SOCIAL SECURITY NUMBER:_________________ SEX: MALE___ FEMALE___
EMPLOYER:_____________________ DR. LIC. #:______________________
RESPONSIBLE PARTY:___________________ SOC SEC:__________________
NAME OF SPOUSE:____________________________(IF APPLICABLE)

DENTAL INSURANCE INFORMATION

DATE OF BIRTH:_______________
EMPLOYEE NAME:____
EMPLOYEE SOC. SEC. NUMBER:______________ ALT. ID.:_____________________
EMPLOYER:_________________________ EMPLOYER PHONE:_________________
NAME OF INSURANCE CO:________________________ GROUP #:______________
INSURACE CO PHONE:__________________RELATIONSHIP TO PATIENT:________

2ND DENTAL INSURANCE

DATE OF BIRTH:_______________
EMPLOYEE NAME:____
EMPLOYEE SOC. SEC. NUMBER:______________ ALT. ID.:_____________________
EMPLOYER:_________________________ EMPLOYER PHONE:_________________
NAME OF INSURANCE CO:________________________ GROUP #:______________
INSURACE CO PHONE:__________________RELATIONSHIP TO PATIENT:________

WHO IS RESPONSIBLE FOR YOUR BILL?______________________________________
HOW WILL YOU BE PAYING FOR SERVICES?
CASH___CK___VISA___MC___OTHER___
REFERRED BY:____

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HEALTH HISTORY

Physician's Name:____ Date of last visit:__________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of lonimin, Adipex, Fastin (brand names of phentermine). Yes___ No___

Check (X) if you have had any of the following:

AIDS/HIV	Yes___No___	Emphysema	Yes___No___	Radiation Treatment	Yes___No___
Anemia	Yes___No___	Epilepsy	Yes___No___	Respiratory Disease	Yes___No__
Arthritis	Yes___No___	Fainting/Dizzy	Yes___No___	Rheumatic Fever	Yes___No___
Artificial Heart Valve	Yes___No___	Glaucoma	Yes___No___	Scarlet Fever	Yes___No___
Artificial Joints	Yes___No___	Headaches	Yes___No___	Shortness of Breath	Yes___No___
Asthma	Yes___No___	Heart Murmur	Yes___No___	Sinus Trouble	Yes___No___
Back Problems	Yes___No___	Heart Problems	Yes___No___	Skin Rash	Yes___No___
Bleeding abnormally		Hepatitis Type____	Yes___No___	Stroke	Yes___No___
with extractions or		Herpes	Yes___No___	Swelling of Feet/ Ankles	Yes___No___
surgery	Yes___No___	H.B.P.	Yes___No___	Swollen Neck Glands	Yes___No___
Blood Disease	Yes___No___	Jaundice	Yes___No___	Thyroid Problems	Yes___No___
Cancer	Yes___No___	Jaw Pain	Yes___No___	Tonsillitis	Yes___No___
Chemical Dependency	Yes___No___	Kidney Disease	Yes___No___	Tuberculosis	Yes___No___
Chemotherepy	Yes___No___	Liver Disease	Yes___No___	Tumor or growth on	
Circulatory Problems	Yes___No___	Low Blood Pressure	Yes___No___	head or neck	Yes___No___
Congenital Heart Lesion	Yes___No___	Mitral Valve Prolapse	Yes___No___	Ulcer	Yes___No___
Cortisone Treatments	Yes___No___	Nervous Problems	Yes___No___	Venereal Disease	Yes___No___
Cough, persistant or		Pacemaker	Yes___No___	Weight Loss,	
bloody	Yes___No___	Psychiatric Care	Yes___No___	unexplained	Yes___No___
Diabetes	Yes___No___				

Do you wear contact lenses? Yes___ No___

Do you **smoke**? Yes___ No___ If Yes, how often?____________

WOMEN:

Are you pregnant? Yes___No___ Due Date:___________________ Are you nursing? Yes___No___

Taking birth control pills? Yes___No___

MEDICATIONS

List any medications you are currently taking and the Correlating diagnosis:

____

____

____

Pharmacy Name:______________________________

Phone: (_____)______________________________

ALLERGIES

___ Aspirin ___Local Anesthetic

___ Barbiturates(sleep pills) ___Penicillin

___ Codeine ___Sulfa

___ Iodine ___Other________

___ Latex___________ _______________

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE (HIPAA)

____

The Exceptional Smile, PLC

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

Acknowledgement of Receipt of Privacy Notice

I, ___________________________, acknowledge that I have received a Notice of Privacy Practices (HIPAA) from the above named practice.

Signature:________________________________ Date:____________

If a personal representative signs this authorization on behalf of the individual, please complete the following.

Personal Representative's Name:____

Relationship to Individual:____

4819 Haggerty Rd/ West Bloomfield, MI 48323
Phone: (248)624-0200/ Fax: (248)624-0201

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Written Financial Policy

Thank you for choosing The Exceptional Smile! Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our 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 may choose from:

- Cash, Check, Visa or Mastercard

  We offer a 5% courtesy adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $1,000 or more.

- NO INTEREST Payment Plans from Care Credit
  - Allow you to pay over time with NO INTEREST
  - Convenient, low monthly payment plans also available
  - No annual fees or pre-payment penalties

Please Note:

The Exceptional Smile requires payment in full (or co-payment in full) the day of treatment.

For larger, more comprehensive treatment plans of $500 or more, a 10% deposit is required to secure your initial treatment appointment.

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

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice. I also understand that I am willing to forfeit my appointment with the applied cancellation fee should I show up 15 min or later into the scheduled appointment time.

The Exceptional Smile charges $25 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)