Gregg S. Resnick, D.D.S

Family Dentistry

Welcome to our office!

Our goal is to help you reach and maintain the level of oral health you desire.
Please provide us with the following information so that we can help you better:

About You

Today's Date:
Name:
I prefer to be called: Male Female
Birth date: Age:
SS#: Driver's License#:
Home Address:

Single Married Divorced Widowed Separated
Phone#: Work#:

Employer:
Employer's Address:

How long there? Occupation:

Where and when are the best times to reach you?

Who may we thank for referring you to us?
Other family members seen by us:

Previous Dentist: Last Visit Date:

Spouse Information
His/Her Name: Birth date:
Employer: Work Phone#:
SS: Driver's License#:

Person Responsible for Account (if other than you):
Work Phone#: Home #:
Billing Address:

Relation: Employer:
SS#: Driver's License#:

Dental Insurance

Primary Dental Insurance
Employer:
Insurance Co. Name:
Insurance Co. Phone#:
Insured's Name: Relation:
Insured's Birth date:
Insured's SS#:
Insured's Employer:

Secondary Dental Insurance
Employer:
Insurance Co. Name:
Insurance Co. Phone#:
Insured's Name: Relation:
Insured's Birth date:
Insured's SS#:
Insured's Employer:

Note: We will bill your insurance as a service to you; however, the financial obligation for any treatment is between you and our office. The insurance company has an obligation to you, not to us. We will do our very best to give you an accurate estimate of that portion of your fees which will be covered your insurance.

Please give us the name of someone who lives near you who we may contact in the event of an emergency:

His/Her Name: Relation:

Work#: Home#:

Medical History

Physician's Name:
Phone#: Last visit:
Your current physical health is: Good Fair Poor
Are you currently under the care of a physician? Yes No
Please explain:
Are you taking any prescription or over-the-counter drugs? Yes No
Please list each one:

Do you smoke or chew tobacco? Yes No
Women: Are you taking birth control pills? Yes No
Are you pregnant? Nursing?

Please list any serious medical conditions that you have ever had:

Are you allergic to any drugs/materials?

Do you require antibiotics before dental treatment?

Have you ever had any of the following medical problems?

Anemia/Radiation Treatment
Artificial Bones/Joints/Valves
Asthma
Cancer
Diabetes
Drug/Alcohol Abuse
Emphysema
Epilepsy
Heart Attack/Stroke
Heart Murmur
Heart Surgery/Pacemaker
Hemophilia
High/Low Blood Pressure
HIV/Aids
Kidney Problems
Psychiatric Problems
Ulcer/Colitis
Venereal Disease

Dr. comments:

Initials:
Date:

Dental History

Why have you come to the dentist today?

Tell me about your relationship with your last dentist.

What is the most important thing our office can do for you?

What do you expect from me personally as your dentist?

If you could wave a magic wand and change anything about your smile, what would it be?

On a scale of 1-10, with 1 being no teeth and 10 being perfect teeth, where are you? Where do you want to be?

How do you see your teeth 10 years from now?

Is there anything that we should know about that would stand in the way of you having the dentistry you want and need being done?

Financial Policies

All fees are due at the time of service unless alternate arrangements have been made in advance. Please ask about our payment options. Returned check fee $25. Late charge of 1.5% each month on all balances not paid within 30 days. Fee for no-show or last minute cancellation(less than 48 hours) of $50/half hour with the doctor, $25/half hour with hygienist. I agree to be responsible for payment of all fees, including those billed to insurance. I agree to pay all actual costs of collecting accounts overdue by over 60 days, including attorney fees and court costs.

Signature Date

The best dental care is based on open communication between office and patient. If any problems or questions arise, do not hesitate to bring them to our attention immediately. Thank you for filling out this form completely. It will enable us to help you more effectively. We are looking forward to getting to know you--your complete satisfaction is our goal!

Gregg S. Resnick DDS

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 acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our 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 your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing of coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "Acknowledgement" to acknowledgement to acknowledgement 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)

_____

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 from signing the Acknowledgement.

_____ _____

Office Personnel (signature) **Office Personnel (print name)**

_____

Date

Patient Consent

Please sign this form below under the heading "Consent 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 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)

_____

Date