Gregg S. Resnick, D.D.S

Family Dentistry

We would like to welcome you and your child to our office.
Our goal is to help your child reach and maintain a high level of oral health. We strive to make going to the dentist a positive experience.
Please provide us with the following information so that we can help you better:

About Your Child

Today's Date:
Name:
Nickname:
Male Female
Birth date: Age:
SS#: Phone #
Home Address:

Parent's Information

Mother's Information: (__Stepmother __Guardian)
Name: Home Phone#

Employer: Work Phone#
SS: Driver's License#:

Father's Information: (__Stepfather __Guardian)
Name: Home Phone#
Employer: Work Phone#

About You

Name: Relation:
Do you have legal custody of this child? Yes No
Parent's marital status: Single Married Divorced
Separated Widowed
Other family members seen by us:
Previous Dentist: Last Visit Date:
Who may we thank for referring you to us?

Person Responsible for Account

Name: Relation:
Billing Address:
Home Phone#
Employer: Work Phone#
SS#: Driver's License#:
Who is responsible for making appointments?
Name: Home Phone#
Work Phone#

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 whom we may contact in the event of an emergency:
His/Her Name: Relation:
Work#: Home#:

Medical History

Has the child had any of the following medical problems?

Heart murmur
Cancer
Diabetes
Rheumatic fever
HIV/Aids
Hemophilia
Asthma
Hepatitis
Tuberculosis
Congenital heart defect
Convulsions/epilepsy
Abnormal bleeding
Hearing impairment
Any operations
Kidney/Liver problems

Handicaps/Disabilities

Allergies to any drugs

Please discuss any serious medical problems that the child has had:

List all drugs that the child is currently taking:

List all drugs that the child is allergic to:

Physician's Name:
Phone#: Last visit:

Dental History

Has the child had any previous dental treatment?

Were these experiences good ones?

Does the child have any finger or thumb habits?

Does the child consume a lot of sweets or sugary drinks?

Do you have fluoridated water?

Do you have any questions or concerns about the child's teeth?

Doctor's comments:

Initials:
Date:

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 24 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