GAYNOR FAMILY DENTAL
Mark A. Gaynor D.D.S., Paul R. Gaynor D.D.S.

Patient Information and Medical History

First Name: _____ Last Name: _____ M____

M___ F___ Minor___ Single___ Married___ Date of Birth: __/__/__

Street Address: _____ City: _____

State: _____ Zip Code: _____

Telephone:(Home)_____(Cell)_____Email:_____

Place of Employment/School: _____

Occupation: _____

Social Security Number: _____ Driver's License: _____

Dental Insurance Company: _____ Group #: _____

Have any member(s) of your family been treated in our office? (yes no)

Who may we thank for referring you to our office? _____

Spouse *OR* Parent Information

Father/Husband: _____ Mother/Wife: _____

_____ _____
Street City State/Zip Street City State/Zip

_____/_____ _____/_____
Home Phone Cell Phone Home Phone Cell Phone

_____ _____
(MM/DD/YYYY) SS# (MM/DD/YYYY) SS#

_____ _____
Employer Employer

_____ _____
Dental Insurance Group # Dental Insurance Group #

Person Responsible for Account

Patient____ Father/Husband____ Mother/Wife____ Guardian____

Who is your personal physician?_____ Doctor's office location:_____

Date of last physical exam: __/__/__ Doctor's phone number:_____

Are you in good health?_____
Are you currently under medical care? And what for?
_____
Do you take medication regularly?_____
_____
Do you need to take an antibiotic before a dental procedure?_____

Are you aware of any changes in your health in the past year?_____
_____
_____
Have you ever been hospitalized? And what for?
_____
_____

Do you have or have you ever been treated for any of the following: (circle "Y" for yes or "N" for no)

Heart disease/attack	(Y/N)	Angina Pectoris	(Y/N)	Rheumatic Fever	(Y/N)	Jaundice	(Y/N)
Congenital Heart Lesion	(Y/N)	Radiation Treatment	(Y/N)	Excessive Bleeding	(Y/N)	Anemia	(Y/N)
Coronary Surgery	(Y/N)	Kidney disease	(Y/N)	Bleeding Disorder	(Y/N)	Stroke	(Y/N)
Artificial Heart Valve	(Y/N)	Tuberculosis	(Y/N)	Liver problems	(Y/N)	Diabetes	(Y/N)
Heart Pacemaker	(Y/N)	Hay Fever/Allergies	(Y/N)	I am on dialysis	(Y/N)	Epilepsy	(Y/N)
High Blood Pressure	(Y/N)	HIV Positive (AIDS)	(Y/N)	Celiac Disease	(Y/N)	Asthma	(Y/N)
Low Blood Pressure	(Y/N)	Arteriosclerosis	(Y/N)	Emphysema	(Y/N)	Arthritis	(Y/N)
Mitral Valve Prolapse	(Y/N)	Heart Murmur	(Y/N)				
Hepatitis A(Infectious)	(Y/N)	Chew tobacco?	(Y/N)	Cancer	(Y/N)	What type? _____	
Hepatitis B/C(Serum)	(Y/N)	Do you smoke?	(Y/N)	How often?_____			

Have you ever experienced a rash, itching, or other reaction after use of any of these medications?(Check if YES)

__Aspirin __Penicillin __Latex
__Local Anesthetics __Erythromycin __Sedatives
__Codeine __Tetracycline __ Sulfa
__Iodine __Other Antibiotics

Is there any other medical conditions about you which we should know? Your medical health may affect our dental treatment._____
_____
_____

Do you have, or have you experienced:

__Shortness of breath on mild exertion
__Chest pain after/during exertions
__Swollen ankles
__Tumor/abnormal growth
__Do you have dry mouth?
__Serious trouble at previous dental visit(s)
__Any artificial replacements and/or implants?
__Are you currently pregnant?
__Do you take birth control pills?
__Do you take estrogens or hormones?

Date of last teeth cleaning: __/__/__

I authorize the release of any dental information necessary to process an insurance claim. I authorize payment of dental benefits to the name provided for professional services rendered. I also understand that when my dental insurance coverage excludes or does not fully cover professional services rendered, I am responsible for the account balance in full.

Patient/Legal Guardian Signature: _____ Date: __/__/__ Dr. Signature:_____

Review Date	Changes in Health Status	Patient Signature	Dr.'s Signature

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Patient HIPAA Acknowledgment 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, upon your request. This Notice of Privacy Practices contains the following that HIPAA requires us to disclose regarding our privacy practice.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain 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 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 other health care professional, provide specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

I acknowledge that I have read and understand all of the above information.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

42611 Garfield Road • Clinton Township, Michigan 48038
(PHONE) 586-228-7766 • (FAX) 586-228-1510 • gaynorfamilydental.com

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Dental Benefit Explanation

It is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs, and we assume that you are as concerned as we are about maintaining your good health.

The term “dental insurance” is misleading. What is commonly known as “dental insurance” is more correctly termed dental benefits. Dental benefits are not intended to pay everything, but to assist with costs of dental treatment. Generally, dental benefits pay a percentage of each procedure up to a set yearly maximum. The benefits available to you are established by which plan package your employer has purchased or you have purchased on your own.

As a courtesy to you, we will submit claims to your dental plan carrier. We also accept benefit assignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion at the time services are provided. However, we do not guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. We take no responsibility for any denials by dental plans.

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Authorization Form for Use or Disclosure of Patient Information

Patient Name (please print): _____

Patient Date of Birth: __/__/__

Address: _____ City: _____

State: _____ Zip Code: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA privacy regulations.

Patient information to be used or disclosed (Please check all that apply):

___ Appointment information ___ Treatment Information

___ Account information ___ Other

___Any information related to our dental office

I authorize Dr. Mark A. Gaynor, Dr. Paul R. Gaynor, and staff to make this use or disclosure to the following person(s) listed below.

The following person(s) may receive this patient information:

_____ Relation to patient listed above: _____

_____ Relation to patient listed above: _____

_____ Relation to patient listed above: _____

Patient/Legal Guardian Signature: _____ Date: __/__/__