



Comprehensive DENTISTRY

5425 Whittaker Road | Ypsilanti, MI 48197
P: (734) 480-0033 | F: (734) 480-0037
www.comprehensivedentistry.net

Welcome to Comprehensive Dentistry!

Thank you for choosing us to meet your dental needs. We are dedicated to helping you achieve optimal dental health.

We are a state of the art dental office that provides patients with comprehensive dental services including, but not limited to:

- Cosmetic restorative treatment – mercury-free fillings, veneers, teeth whitening (in-office and take home options available)
- Digital x-rays – minimizing patient exposure to radiation
- Intraoral cameras in all rooms for diagnostic treatment and to give patients before and after treatment views
- Nitrous oxide gas
- Crowns, implants, bridges, and dentures
- Root canal therapy
- Periodontal therapy
- Invisalign

Office and Financial Policies:

Payment is due at the time of treatment:

- We accept cash, check, and all major credit cards (Visa, MasterCard, American Express & Discover).
- We also have a payment plan called **Care Credit** that allows you to start treatment today and spread out your payments over time. It allows flexible payment options for our patients.
- It is requested that you pay in full on the day of service. This includes co-pays and deductibles.
- Overpayment on your account after insurance payments are posted will remain on your account and used towards future services, unless a refund is requested.
- In the event that your insurance company should deny payment for whatever reason, every effort will be made by our office to receive payment.
- After 90 days, the insurance balance is patient's responsibility.

Minor Patients: Minor patients under the age of 18 must be accompanied by a parent or guardian to all appointments. If a minor is accompanied by someone other than a parent or guardian or alone, written permission must be provided. IF you are planning to leave the office at any time during the minor's

appointment, you must sign a consent form and provide us with an emergency contact number.

Office Hours:

Monday: 8am-7pm

Tuesday-Thursday: 7am-7pm

Friday: 7am-5pm

Office closed on weekends*

***Emergencies:** Our office provides on-call service for emergencies by calling our office number – (734) 480-0033. You will be directed to the emergency number. Calls will be returned between the hours of 8am-10pm.

Facts About Insurance:

- We ask that you realize that we do not work for an insurance company, rather – we work 100% for our patients.
- We feel that insurance can be a great benefit for many patients and want you to know that we will do everything in our power to ensure you get every benefit allotted in your insurance benefit.
- The treatment we recommend, however, and the fees we charge, will always be based on your individual needs – not your insurance coverage.



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Patient Information

Date _____

Patient's Name _____
Last First Middle

Mailing Address _____
Street City Zip

Phone #: [H] _____ [M] _____ [W] _____

DOB: ____/____/____ SSN: ____-____-____ E-Mail: _____

Employer: _____ Occupation: _____

Marital Status: Single ___ Married ___ Widowed ___ Separated ___ Divorced ___ Other ___

Spouse's Name _____ Relationship to Patient _____

Spouse's Phone #: _____ DOB: ____/____/____ SSN: ____-____-____

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

Dental Insurance Information

Insured's Name: _____ DOB: ____/____/____ SSN: ____-____-____

Insurance Company _____

Subscriber ID: _____ Group #: _____

Do you have dual coverage? Yes ___ No ___ (if so, please fill out below)

Insured's Name: _____ DOB: ____/____/____ SSN: ____-____-____

Insurance Company _____

Subscriber ID: _____ Group #: _____

Emergency Contact

Name: _____ Phone #: _____ Relationship: _____

Medical History

Physician _____ Date of Last Visit _____
Address _____ Phone #: _____

Please Circle Yes or No (if **yes**, please fill in the details):

Yes No Are you taking any medication(s)? _____
Yes No Are you allergic to any medication(s)? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have you seen a physician in the last 12 months? Why? _____

Female Patients Only:

Yes No Are you pregnant? _____
Yes No Have menstruation started? _____

Circle any of the medical conditions below that you have had or currently have:

- Abnormal Bleeding/Hemophilia
- Anemia
- Arthritis
- Asthma/Hay Fever
- Bone Disorders
- Congenital Heart Defect
- Diabetes
- Dizziness
- Epilepsy
- Gastrointestinal Disorders
- Heart Problems/Heart Murmur
- Hepatitis/Liver Problems
- High Blood Pressure
- HIV/AIDS
- Kidney Problems
- Nervous Disorders
- Pneumonia
- Prolonged Bleeding
- Radiation/Chemo-therapy
- Rheumatic Fever
- Tuberculosis
- Tumor/Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Dental History

General Dentist _____ Date of Last Visit _____

What concerns you most about your teeth? _____

Please Circle Yes or No (if **yes**, please fill in the details):

Yes No Are you presently in any dental pain?
Yes No Have you ever experienced any unfavorable reaction to dentistry?
Yes No Have your wisdom teeth been removed?
Yes No Have you ever lost or chipped any teeth?
Yes No Have there been any injuries to the face, mouth, or teeth?
Yes No Is part of your mouth sensitive to temperature? Where?
Yes No Is part of your mouth sensitive to pressure? Where?
Yes No Do your gums bleed when you brush?
Yes No Have you ever seen an orthodontist? If yes, who and when?
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
Yes No Are you aware of your jaw clicking or popping?
Yes No Are you aware of clenching your teeth during the day?
Yes No Have you ever been told that you grind your teeth?
Yes No Do you have "tension" headaches?
Yes No Have you ever experienced chronic ringing in your ears?



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Appointment Policy

In order to ensure quality dental care, it is imperative that our patients understand the manner in which we schedule our appointments. We value your time and make every effort to stay on or ahead of schedule.

- **Scheduling Appointments:** Please schedule your return visit before you leave the office. If you choose to postpone scheduling your appointment, it could be several weeks or months before another appointment becomes available, thus prolonging treatment.
- **Missed Appointments:** If you miss an appointment, it could be several weeks or months before another appointment becomes available. All missed appointments or those not cancelled within 48 hours to the appointment must be rescheduled as soon as the office allows. After the first missed appointment, the office will post a **\$50.00 missed appointment charge** to your account for each failed appointment.
- **Prime Time Appointments:** We are open early and late hours to meet the needs of our wonderful patients. Appointments scheduled between 7:00am- 9:00am and 4:00pm-7:00pm are highly sought after and requested. These appointments are considered Prime Time Appointments. Patients who cancel or reschedule without sufficient notice, or fail to show up for Prime Time Appointments **will not be rescheduled during** these times.

Patient /Guardian Signature

Date

Privacy Policy

Refer to next page (6) & keep for your records

- ❖ I was given a copy of Comprehensive Dentistry's Privacy Policy for my records.
- ❖ I have reviewed and understand Comprehensive Dentistry Privacy Policy.
- ❖ I have been offered or received a copy of the Official Notice of Privacy Practices.

➤ **Signature** _____ **Date:** _____

- ❖ I give permission to allow Comprehensive Dentistry to discuss my/this patient's treatment and/or financial matters with:

Name _____ **Relationship:** _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. We will also disclose protected health information to other physicians who may be treating you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities, including text and/or e-mail appointment reminders.

We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.

Marketing: We may use your photographs and/or first name only - with your verbal and/or written consent or from events hosted by Comprehensive Dentistry for social media purposes, website, newsletter, or other advertising purposes.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Questions?

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. We support your right to protect the privacy of your protected health information.

Contact: Comprehensive Dentistry, 5425 Whittaker Road, Ypsilanti, MI 48197, P: (734) 480-0033