W E L C O M E

In order to ensure your maximum oral health and allow us to prescribe the proper medications, it is very important that we know all medical and dental information about you. Please complete every box on this form, even if the answer is "N/A" (not applicable). This information will be kept in the strictest confidence.

You also should know that changes in other parts of your body may affect the oral cavity and what dental treatment can be done, even if they seem unconnected. Cardiac (heart) problems, artificial joints and diabetes are just some examples.

Will you please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions have changed since we last saw you? Yes __ No__. Thank You.

1. Patient Information

Date ____________________

NAME ____________________
LAST FIRST MI

Address ____________________

____
City State Zip

I prefer to be called: ____________ TITLE ________
MR MRS MS DR

Birth date ________ Gender: F__ M__ Age______

__Single __Married __Widowed __Separated __Divorced

Patient SS# _____-_____-_____

Patient Drivers License# ____________________

If patient is a minor, give parent's or guardian's name: ________

____

Occupation ____________________

Employer ____________________

Spouse's Name ____________________

Spouse's Occupation ____________________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________

3 Phone Numbers

Home Phone ____________________

Work ____________ Ext ____________

CELL ____________ PAGER ________

Spouse's Work ____________________

Spouse's work: ____________________

Spouse's cell: ____________________

e-mail address ____________________

IN CASE OF EMERGENCY, CONTACT
(Specify someone who does not live in your household.)

Name ____________________

Relationship ____________________

Home Phone ____________________

Work Phone ____________________

Family Physician's Name ____________________

Physician's Phone# ____________________

Dental Insurance (Primary)

Who is responsible for this account? ____________

SS# ____________ Birthdate ________

Relationship to Patient: ____________

Insurance Co. ____________________

Group # ____________________

Is Patient covered by another insurance plan Y___ N___

Secondary Dental Insurance

Subscriber name ____________________

SS# ____________ Birth date ________

Insurance CO ____________________

Group# ____________________

Relationship to Minor (if applicable) Date

Patient Name	
Patient Account No.	Medical Alert

MEDICAL HISTORY

1. Physician's Name ______ Phone ( ) ______
   Have you had any medical care within the past two years? .... Yes ○ No ○
   Describe ______
2. Have you taken any medication or drugs during the past two years? .... Yes ○ No ○
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? .... Yes ○ No ○
   If yes, please list name and dosage ______
4. Have you ever taken prescription medications for weight loss (diet pills)? .... Yes ○ No ○
   If yes, did you take any of the following? (circle if yes) Fen-Phen ☐ Pondimen ☐ Redux ☐ Other ☐
   If yes to any of the above, did you have a medical exam for heart issues? .... Yes ○ No ○
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? .... Yes ○ No ○
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? .... Yes ○ No ○
   If yes, please specify ______
7. Have you been a patient in the hospital during the past five years? .... Yes ○ No ○
8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes ○ No ○	Ulcers	Yes ○ No ○	Hepatitis ☐ A ☐ B ☐ C (circle)	Yes ○ No ○
Chest Pain	Yes ○ No ○	Diabetes	Yes ○ No ○	Venereal Disease	Yes ○ No ○
Congenital Heart Disease	Yes ○ No ○	Thyroid Problems	Yes ○ No ○	A.I.D.S./H.I.V. Positive	Yes ○ No ○
Heart Murmur	Yes ○ No ○	Glaucoma	Yes ○ No ○	Cold Sores/Fever Blisters	Yes ○ No ○
High/Low Blood Pressure	Yes ○ No ○	Contact lenses	Yes ○ No ○	Blood Transfusion	Yes ○ No ○
Mitral Valve Prolapse	Yes ○ No ○	Emphysema	Yes ○ No ○	Hemophilia	Yes ○ No ○
Artificial Heart Valve/Pacemaker	Yes ○ No ○	Chronic Cough	Yes ○ No ○	Sickle Cell Disease	Yes ○ No ○
Rheumatic Fever	Yes ○ No ○	Tuberculosis	Yes ○ No ○	Bruise Easily	Yes ○ No ○
Arthritis/Rheumatism	Yes ○ No ○	Asthma	Yes ○ No ○	Liver Disease/Yellow Jaundice	Yes ○ No ○
Cortisone Medicine	Yes ○ No ○	Hay Fever/Allergy/Hives	Yes ○ No ○	Neurological Disorders	Yes ○ No ○
Swollen Ankles	Yes ○ No ○	Latex Sensitivity	Yes ○ No ○	Epilepsy or Seizures	Yes ○ No ○
Stroke	Yes ○ No ○	Sinus Trouble	Yes ○ No ○	Fainting or Dizzy Spells	Yes ○ No ○
Diet (Special/Restricted)	Yes ○ No ○	Radiation Therapy	Yes ○ No ○	Nervous/Anxious	Yes ○ No ○
Artificial Joints (hip, knee, etc.)	Yes ○ No ○	Chemotherapy	Yes ○ No ○	Psychiatric/Psychological Care	Yes ○ No ○
Kidney Trouble	Yes ○ No ○	Tumors	Yes ○ No ○		

9. Have you lost or gained more than 10 pounds in the past year? .... Yes ○ No ○
10. Do you have or have you had any disease, condition, or problem not listed? .... Yes ○ No ○
    If yes, please list: ______
11. **Women:** Are you pregnant or think you could be pregnant? Yes ○ ☐ Months No ○ **Nursing?** Yes ○ No ○
12. Do you use birth control prescriptions? .... Yes ○ No ○

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature ______ Date ______

History Review

Submit by Email | Print Form

Dentist Signature ______ Date ______

[illegible] DENTAL HISTORY

tient Name

tient Account No.

Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? ____________________

Date of Last Dental Visit ________ **Last Dental Cleaning** ________ **Last Full Mouth X-rays** ________

What was done at your last dental visit? ____________________

Previous Dentist's Name ____________________

Address ____________________ State ______ Zip ______

Telephone ____________________

How often do you have dental examinations? ____________________

How often do you brush your teeth? ________ How often do you floss? ________

Have you ever used or are currently using topical fluoride? Yes○ No○

What other dental aids do you use? (Interplak, toothpick, etc.) ____________________

Do you have any dental problems now? Yes○ No ○

If yes, please describe: ____________________

Are any of your teeth sensitive to:

- Hot or cold? Yes ○ No ○
- Sweets? Yes ○ No ○
- Biting or Chewing? Yes ○ No ○
- Have you noticed any mouth odors or bad tastes? Yes ○ No ○
- Do you frequently get cold sores, blisters or any other oral lesions? Yes ○ No ○
- Do your gums bleed or hurt? Yes ○ No ○
- Have your parents experienced gum disease or tooth loss? Yes ○ No ○
- Have you noticed any loose teeth or change in your bite? Yes ○ No ○
- Does food tend to become caught in between your teeth? Yes ○ No ○
- If yes, where? ________

Do you:

- Clench or grind your teeth while awake or asleep? Yes ○ No ○
- Bite your lips or cheeks regularly? Yes ○ No ○
- Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes ○ No ○
- Mouth breathe while awake or asleep? Yes ○ No ○
- Have tired jaws, especially in the morning? Yes ○ No ○
- Snore or have any other sleeping disorders? Yes ○ No ○
- Smoke/chew tobacco or use other tobacco products? Yes ○ No ○

Have you ever had:

- Orthodontic treatment? Yes ○ No ○
- Oral Surgery? Yes ○ No ○
- Periodontal treatment? Yes ○ No ○
- Your teeth ground or the bite adjusted? Yes ○ No ○
- A bite plate or mouth guard? Yes ○ No ○
- A serious injury to the mouth or head? Yes ○ No ○
- If so, please describe, including cause ________

Have you experienced:

- Clicking or popping of the jaw? Yes ○ No ○
- Pain? (joint, ear, side of face) Yes ○ No ○
- Difficulty in opening or closing the mouth? Yes ○ No ○
- Difficulty in chewing on either side of the mouth? Yes ○ No ○
- Headaches, neckaches or shoulder aches? Yes ○ No ○
- Sore muscles (neck, shoulders)? Yes ○ No ○

Are you satisfied with your teeth's appearance? Yes ○ No ○

Would you like to keep all of your teeth all of your life? Yes ○ No ○

Do you feel nervous about having dental treatment? Yes ○ No ○
If so, what is your biggest concern? ________

Have you ever had an upsetting dental experience? Yes ○ No ○
If yes, please describe ________

ave you ever been told to take a pre-medication prior to dental treatment? Yes○ No ○

there anything else about having dental treatment that you would like us to know? Yes○ No○

yes, please describe ____________________

(Please complete other side)

John A. Dobry, DDS

15870 19 Mile Road, Suite 160 ◆ Clinton Township, MI 48038 ◆ (586) 286-0790

Financial Policy

Our office strives to provide the highest quality dental care at affordable prices. Our patients receive prompt attention and excellent service. We believe that a satisfied patient returns for additional services, refers others to the practice and pays their bill promptly. To help maintain a good relationship with our patients, this office has adopted a written financial policy. The purpose of this policy is to eliminate confusion or misunderstanding concerning financial arrangements offered by our office. Our office communicates this policy to each patient.

For those with insurance benefits, we are happy to bill your insurance as a courtesy to you. Please note that your insurance contract exists solely between you and your insurance carrier. We will file your insurance claim, but we cannot guarantee any benefits. Your insurance plan is a benefit to you to help offset the cost of necessary dental care. Ultimately, you are responsible for the entire cost of your dental therapies. Any questions or comments regarding your benefits should be directed to your insurance carrier.

1. Payment at the time of service is expected, including the estimated portion of the amount that insurance does not cover. Our office accepts the following payment methods: Cash, Check, MasterCard and VISA.

2. When the patient's portion cannot be paid at the time of service and payment arrangements extend beyond 12 months, an interest rate of 9% per annum will be charged on all outstanding balances.

3. A credit report will be generated on each new patient that is offered payment arrangements. A credit report may also be generated on established patients, prior to extending payment arrangements. Payment history with our office will be taken into consideration when establishing payment arrangements.

4. Interest of 9% per annum will be assessed on the patient's portion of the unpaid balance as noted above (#2). A written, signed agreement will be completed at our office, which explains the number of payments, interest rate and total interest to be paid over the term of the agreement.

5. A statement for services rendered will be mailed to you at the end of each month. Receipt of payment is expected by the 10th of the month. The patient's payment should be mailed with the top portion of the statement to establish the proper crediting of the account.

6. Your account due is considered delinquent if the requested payment is not received by the tenth (10th) of the month. If payment is not received, a late charge of ¾% per month ($1.00 minimum) will be assessed and will appear on the next statement. The annual percentage rate is 9%.

7. A $20.00 charge will be billed to your account for any check returned by the bank for any reason. We will resubmit the check for payment to the bank one time. However, if funds are still insufficient, we will not accept payments by check from you in the future.

8. There will be no charge for a broken appointment with 24 hours' notice. This enables us to fill the reserved time slot from our list of patients who are able to come on short notice. Broken appointments with less than 24 hours' notice will incur a $20.00 fee.

9. Delinquent accounts may be sent to a collection agency.

☐ Yes, I am interested in payment arrangements that may be made available to me in order to complete my dental treatment.

I have read and understand the financial policy of Dr. Dobry and agree to all the terms described in it.

____

Patient Signature/Guardian Signature Date

John A. Dobry D.D.S.
15870 19 Mile Road Suite 150
586-286-0790
Fax: 586-286-3682
dr.dobry58@gmail.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name____

Patient number ______________________________________

Patient address ______________________________________

Patient phone number _________________________________

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about dental health services] under the following terms and conditions, The person you can authorize my information are:

______________________________(Relationship to pt)______________Date__________

(Name or person)

______________________________(Relationship to pt)______________Date__________