



WELCOME TO INFINITY DENTAL EXCELLENCE

Today's Date: _____ Email Address: _____

Name: _____ I prefer to be called: _____ Male Female
Last First MI Mr. Mrs. Ms. Dr.

Birthdate: ___/___/___ Age: _____ Social Security #: _____ Single Married Divorced Widowed Separated

Home Address: _____
Street City State ZIP

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Ext: _____

Drivers License #: _____ When & where are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State ZIP

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: _____ Relationship: _____ Work Phone: (____) _____ Home Phone: (____) _____

Address: _____
Street City State ZIP

PERSON RESPONSIBLE FOR THE ACCOUNT IF OTHER THAN YOURSELF

Name: _____ Relationship: _____ Work Phone: (____) _____ Home Phone: (____) _____

Employer: _____ Work Phone: (____) _____ Ext: _____ Driver's License #: _____

Billing Address: _____
Street City State ZIP

SPOUSE INFORMATION

Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone: (____) _____ Ext: _____ Driver's License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? Yes No Medical Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name: _____ Phone: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street City State ZIP

Insured's Name: _____ Insured's Social Security #: _____

Birthdate: ___/___/___ Relationship: _____ Insured's Employer: _____

Employer's Address: _____
Street City State ZIP

Secondary Insurance Dental Coverage? Yes No Medical Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name: _____ Phone: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____

Insured's Name: _____ Insured's Social Security #: _____

Birthdate: ___/___/___ Relationship: _____ Insured's Employer: _____

Employer's Address: _____

CONTINUED ON BACK

MEDICAL HISTORY

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name: _____ Phone: (_____) _____ Date of last medical exam: _____

What was the exam for? _____ Current Physician: _____

	Y	N
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/>	<input type="checkbox"/>
Are you under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious head or neck injury?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any medications or supplements?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please list the dose and how often (use back of paper if needed)

	Y	N
Are you pregnant or trying to get pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Local Anesthetics
- Acrylic
- Codeine
- Metal
- Latex
- Sulfa Drugs
- Other: _____

Do you take or have you taken Phen-Fen or Redux?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>
Are you in a special diet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>

Family History Unknown?

YES NO

CHECK ALL THAT APPLY:

	HAVE	HAD	FAMILY HISTORY	
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/Dizziness
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes
Artificial Joint:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
What Joint? _____				Hay Fever
When? _____				Heart Attack/Failure
Athma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pace Maker
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C
Type? _____				Herpes
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
When? _____				High Cholesterol
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Disease
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type? _____
Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease

	HAVE	HAD	FAMILY HISTORY	
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
When? _____				
Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wear a c-pap?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE?

If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

Our purpose in conducting this New Patient Interview is to learn more about you allowing our dental team to supply you with all of the important information you will need to make informed decisions regarding your overall health.

Patient Name: _____ Date: _____

1. We like to treat our patients like family. Before we get to your dental health, we like to get to know you as a person. What would you like to share about yourself?
2. What would you like to know about our dental practice? Doctor, Hygienists, Assistants?
3. What motivated you to make an appointment with us?
4. What are your thoughts about going to the dentist?
5. What are your objectives regarding your dental health? Check those that apply:
 Pain-free Bright White Smile Keep your natural teeth for a lifetime
 Healthy Gums Fresh Breath Straighter Teeth Other
6. What dental concerns have you had in the past? Currently experiencing? How do they affect you?
7. Do you experience headaches, neck or back pain? Yes No
8. So that we may serve you personally and comfortably, which of the following are most important?
 On time start to finish
 Clear understanding of problem and recommended solutions
 To know everything that is going on in your mouth, regardless of the severity
 To handle only your most pressing needs
 To be called after your visit to see how you are doing
 To be done with treatment sooner with longer appointments
 Multiple shorter appointments to complete treatment
 Call to remind you of the exact time of your appointment
9. We are a zero balance office. If there is an investment in your health, what payment method is best?
 Cash Check Credit Card Interest-Free Financing
10. We respect our patients' time; therefore we do everything we can to work efficiently on your treatment. We request the same from you. Please be on time and give us 48 hours' notice if an emergency occurs.
11. Who may we thank for referring you?
12. Our practice is built on referrals. Know someone looking for a great dentist office? Refer them for a \$25 credit, and they get \$25 too!
13. Do you have any other concerns or questions?

THANK YOU FOR TAKING THE TIME TO FILL THIS OUT FOR US. WE REALLY APPRECIATE IT!





Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

Patient Name: _____ Date: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Infinity Dental may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient, handling billing and payment, and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Infinity Dental has a detailed document called the **Notice of Privacy Practices**. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the **Notice** before signing this agreement. If I ask, Infinity Dental will provide me with the most current **Notice of Privacy Practices**.

My signature below indicates that I have been given the chance to review such copy of the **Notice of Privacy Practices**. My signature means that I agree to allow Infinity Dental Excellence to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Infinity Dental Excellence has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative)

Date

Relationship to Patient if signed by another party

Date

You may obtain a copy of **Notice of Privacy Practices**, including any revisions of our **Notice** at any time by contacting: Infinity Dental Excellence, 4565 Wilson Ave SW, Ste. 2A, Grandville, MI 49418.
Phone: 616.538.0770.



INFINITY DENTAL AND YOUR INSURANCE COMPANY: HOW THEY WORK TOGETHER

The staff at Infinity Dental Excellence is pleased that you have Insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of those benefits. With this in mind, please read the information on our insurance claims process so that we can work together to ensure this benefit.

Do you accept my insurance? How much will they pay?

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE.

I thought I paid my portion, but I got a bill. Why?

We base the patient portion of your bill on our most current data but there are many factors that can affect this estimate. There may be a deductible (Individual or family) or you may have received treatment in another office prior to joining Infinity Dental Excellence, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies DO NOT (and cannot in most cases) notify us of the changes to your benefits, they only notify you. Your insurance company also has what they call reasonable and customary charges and these are what the percentage they pay is based on. (Example: if we charge \$89 for a prophylaxis and the insurance company's reasonable and customary fee is \$70, they pay 100% of \$70, therefore the remaining \$19 is your responsibility).

Insurance didn't pay, now what?

We bill your insurance as a courtesy. If yours does not pay within 90 days, Infinity Dental Excellence reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, part of that legal contract. **ULTIMATELY, YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED IN OUR OFFICE.**

Financial Options

Infinity Dental Excellence does request payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, Personal Checks, and money orders. If you are in need of an extended finance option, we also work with Care Credit and Simple Pay, who offer interest-free or longer terms with an interest-bearing revolving charge designed to meet your treatment plan needs.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Infinity Dental.

Signature

Date



Infinity Dental Excellence
4565 Wilson Ave SW Ste. 2A
Grandville, MI 49418

Our Policy of Care and Payment

Ensuring that our patients receive high quality care is the goal of our practice.

Payment is due at the time of treatment. We accept cash, check and major credit cards. We also have a payment plan called Care Credit, that allows you to start treatment today and spread payments over time.

Payment Options

1. Cash
2. Check
3. Major Credit Cards
4. Care Credit
5. Simple Pay

Applying for Care Credit only takes a few minutes and there is no fee to apply. Applying for Simple Pay doesn't affect your credit, and everyone qualifies.

Please indicate below the form of payment you choose to settle your account:

Check one:

- Cash
- Check
- Major Credit Care
- Care Credit (subject to credit approval.) If credit application is declined, another form of payment listed above is required.
- Simple Pay

Signature of Patient/Responsible Party

Date