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?	☐	☐
Are you under the care of a physician?	☐	☐
Have you ever had a serious head or neck injury?	☐	☐
Are you taking any medications or supplements?	☐	☐

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

	Y	N
Do you take or have you taken Phen-Fen or Redux?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐
Are you in a special diet?	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐

	Y	N
Are you pregnant or trying to get pregnant?	☐	☐
Are you taking contraceptives?	☐	☐
Are you nursing?	☐	☐

Are you allergic to any of the following?

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

Family History Unknown? ☐ YES ☐ NO

CHECK ALL THAT APPLY:

	HAVE	HAD	FAMILY HISTORY
Acid Reflux	☐	☐	☐
AIDS/HIV Positive	☐	☐	☐
Alzheimer's Disease	☐	☐	☐
Anaphylaxis	☐	☐	☐
Anemia	☐	☐	☐
Angina	☐	☐	☐
Arthritins/Gout	☐	☐	☐
Artificial Heart Valve	☐	☐	☐
Artificial Joint:	☐	☐	☐
What Joint? __________			
When? __________			
Athsma	☐	☐	☐
Blood Disease	☐	☐	☐
Blood Transfusion	☐	☐	☐
Breathing Problem	☐	☐	☐
Bruise Easily	☐	☐	☐
Cancer	☐	☐	☐
Type? __________			
Chemotherapy	☐	☐	☐
When? __________			
Chest Pains	☐	☐	☐
Cold Sores/Fever Blisters	☐	☐	☐
Congenital Heart Disorder	☐	☐	☐
Convulsions	☐	☐	☐
Cortisone Medicine	☐	☐	☐
Diabetes	☐	☐	☐
Drug Addiction	☐	☐	☐
Dry Mouth	☐	☐	☐
Easily Winded	☐	☐	☐
Emphysema	☐	☐	☐
Epilepsy	☐	☐	☐
Excessive Bleeding	☐	☐	☐
Excessive Thirst	☐	☐	☐
Fainting Spells/Dizziness	☐	☐	☐
Frequent Cough	☐	☐	☐
Frequent Diarrhea	☐	☐	☐
Frequent Headaches	☐	☐	☐
Genital Herpes	☐	☐	☐
Glaucoma	☐	☐	☐
Hay Fever	☐	☐	☐
Heart Attack/Failure	☐	☐	☐
Heart Murmur	☐	☐	☐
Heart Pace Maker	☐	☐	☐
Heart Trouble/Disease	☐	☐	☐
Hemophilia	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B or C	☐	☐	☐
Herpes	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Hives or Rash	☐	☐	☐
Hypoglycemia	☐	☐	☐
Inflammatory Disease	☐	☐	☐
Type? __________			
Irregular Heartbeat	☐	☐	☐
Kidney Problems	☐	☐	☐
Leukemia	☐	☐	☐
Liver Disease	☐	☐	☐
Low Blood Pressure	☐	☐	☐
Lung Disease	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Osteoporosis	☐	☐	☐
Pain in Jaw Joints	☐	☐	☐
Parathyroid Disease	☐	☐	☐
Phsychiatric Care	☐	☐	☐
Radiation Treatments	☐	☐	☐
When? __________			
Recent Weight Loss	☐	☐	☐
Renal Dialysis	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatism	☐	☐	☐
Scarlet Fever	☐	☐	☐
Shingles	☐	☐	☐
Sickle Cell Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sleep Apnea	☐	☐	☐
Do you wear a c-pap?	☐	☐	☐
Spina Bifida	☐	☐	☐
Stomach/Intestinal Disease	☐	☐	☐
Stroke	☐	☐	☐
Swelling of Limbs	☐	☐	☐
Thyroid Disease	☐	☐	☐
Tonsilitis	☐	☐	☐
Tuberculosis	☐	☐	☐
Tumors or Growths	☐	☐	☐
Ulcers	☐	☐	☐
Venereal Disease	☐	☐	☐
Yellow Jaundice	☐	☐	☐

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 prophy 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 Card**

☐ **Care Credit (subject to credit approval.) If credit application is declined, another form of payment listed above is required.**

______________________________ ______________

Signature of Patient/Responsible Party **Date**