TIME 04:29 PM

DATE 3/19/2024

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Gender: ☐ Male ☐ Female ☐ Unknown Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

NP in system

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 4:27 PM

Patrick Michel DMD

2021 Medical History Form

Date 3/19/2024

Patient Name: Birth Date: Date Created:

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.

Are you under a physician's care now?	○ Yes ○ No	If yes	
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes	
Do you have any surgically placed metal in your body? Such as metal pins, plates, or joint replacements	○ Yes ○ No	If yes	
Have you ever been told that you need an antibiotic premedication prior to dental treatment?	○ Yes ○ No	If yes	
Are you taking any medications? If so please list.	○ Yes ○ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Do you use or have you used tobacco or electronic cigarette? If so how much?	○ Yes ○ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin/Amoxicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Foods	☐	If yes	
Other allergies not listed above	☐	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV+	○ Yes ○ No	Angina/Chest Pain	○ Yes ○ No	Alzheimer's /Dementia	○ Yes ○ No	ADD/ADHD	○ Yes ○ No
Asthma	○ Yes ○ No	Anxiety/Depression	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No	Anemia	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Artificial Joint	○ Yes ○ No	Autoimmune Disease	○ Yes ○ No	Autism	○ Yes ○ No
Blood Disorders	○ Yes ○ No	Bruise Easily	○ Yes ○ No	Blood Transfusion	○ Yes ○ No	Bacterial Endocarditis	○ Yes ○ No
Cancer	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Cold sore/ Fever Blisters	○ Yes ○ No	Congential Heart Disorder	○ Yes ○ No
Congestive Heart Failure	○ Yes ○ No	COPD	○ Yes ○ No	Diabetes	○ Yes ○ No	Drug Addition	○ Yes ○ No
Down Syndrome	○ Yes ○ No	Epilepsy/Seizures	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Frequent Headaches	○ Yes ○ No
Frequent Cough	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Glaucoma	○ Yes ○ No	Herpes	○ Yes ○ No
Heart Attack	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Hepatitis A, B or C	○ Yes ○ No
Kidney Disease	○ Yes ○ No	Liver Disease	○ Yes ○ No	Low Blood pressure	○ Yes ○ No	Lung Disease	○ Yes ○ No
GERD/Acid Reflux	○ Yes ○ No	Osteoporosis/penia	○ Yes ○ No	Radition Treatments	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Special Needs	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Stroke	○ Yes ○ No	Sjogren's Syndrome	○ Yes ○ No
Shingles	○ Yes ○ No	Sinus Trouble/Seasonal Allergies	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Pacemaker	○ Yes ○ No	Organ Transplant/Recipients	○ Yes ○ No	Mental Health/Psychiatric Care	○ Yes ○ No	COVID-19/Coronavirus	○ Yes ○ No

Have you ever had or do you have any illness not listed above?	○ Yes ○ No	If yes	
Please provide Emergency Contact and phone number.		Comment	

Dental History

When was your last dental appointment? Please provide previous dentist name and phone number.		Comment	
When were your last dental xrays taken?		Comment	
How often do you brush your teeth?		Comment	
How often do you floss your teeth?		Comment	

Do you have or have you had the following?

Periodontal Surgery	○ Yes ○ No	Implants	○ Yes ○ No	Braces	○ Yes ○ No	Extractions	○ Yes ○ No
Mouth Sores	○ Yes ○ No	Root Canal	○ Yes ○ No	TMJ Issues	○ Yes ○ No	Abscessed Tooth	○ Yes ○ No
Dry Mouth	○ Yes ○ No	Sensitive Teeth	○ Yes ○ No	Oral Cancer	○ Yes ○ No	Denture/Partial	○ Yes ○ No

Do you ever (choose all that apply)

Clench	○ Yes ○ No	Grind	○ Yes ○ No
Mouth Breather	○ Yes ○ No	Snore	○ Yes ○ No

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:

X_____ Date:_____

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received or have been given the opportunity to receive/review a copy of

Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have been given the opportunity to receive/review this organization's Notice of our Privacy Practices.

Patient Name (Type or Print)

Patient's Date of Birth

Signature of Patient or Parent/Legal Guardian

Date Signed

Name of parent/legal guardian if signing for patient

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify): _____

Notes: _____

Patrick M. Michel, DMD, PA

PATIENT'S AUTHORIZATION REQUEST FORM

You may give Dr. Patrick Michel written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below:

PLEASE PRINT:

Patient's Name:_____Middle Initial:____Last Name:_____

Patient's Date of Birth:_____/_____/_____

Patient's Address:_____

City:_____State:_____Zip:_____

Phone Number:_____

At my request, I authorize Patrick M. Michel, DMD, PA to disclose my Protected Health Information to:

Name:_____Relationship to Patient:_____

Name:_____Relationship to Patient:_____

Name:_____Relationship to Patient:_____

I, _____, authorize Patrick M. Michel, DMD, PA to disclose the following PHI to the person/ entity listed above. Check all that apply:

____Patient Information
___Payment Information
___Claims Information
___All services from a specific health care provider
___Benefit Information
___Explanation of Insurance Benefits
___All Information Requested

Patient's
Signature:_____Date:_____

(If the patient is a minor, the guardian needs to sign.)

Patrick M. Michel, DMD, PA
3314 Healy Drive, Suite 101
Winston-Salem, NC 27103

FINANCIAL POLICY

Thank you for selecting our office as your dental provider. The following is a statement of our financial policy which we ask that you **read, understand and sign prior to any treatment.** We are committed to the best possible dental care and we are happy to discuss our professional fees with you at any time during our normal office hours. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our providing you with financial policy, or your responsibility. Payment is requested at each appointment as service is rendered and can be made by **Cash, Check, Master Card, Visa, American Express, Discover, or Care Credit.** Please be aware that if you are a parent bringing a child to our office you are legally responsible for payments on all charges. We cannot send statements to other addresses.

DENTAL INSURANCE INFORMATION

As a courtesy to you, our patients, we will file your dental insurance claim for you. We also, as a courtesy to you, will accept assignment of benefits. We will only accept this assignment of benefits after you are a patient of record with us. Once we have verified your insurance benefits, we will begin filing your claims for you. For appointments such as cleanings, we will bill the insurance company. If you need to return for restorative, we will collect your yearly deductible at the time the service is rendered. If you are in need of a crown, bridge, or denture, we ask that you pay a portion of what you will be responsible for at the initial appointment, and that the remaining portion be paid at the delivery appointment. Please keep in mind we estimate what we think the insurance will pay. Once the insurance company reimburses us, you will be billed for any remaining balance.

You, the patient, are responsible for your entire account balance. If, for some reason, your insurance company becomes unduly difficult to deal with, we ask that you proceed with whatever measures you deem appropriate to collect on your claim. Please provide us with the following information in order to file your claim:

Patient's Name:_____
Employee Name:_____
Employee Date of Birth:_____
Employee Social Security Number:_____
Company Where Employed:_____
Insurance Company Name & Number:_____

I authorize the release of any information concerning mine or my child's dental care, advice, and treatment provided for the purposes of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me and I understand that I am financially responsible for payments in full of all accounts.

Signature of patient, parent, or guardian_____Date:_____