Sanilac Smiles Dental Care
Anthony Burdua, DDS

PATIENT INFORMATION

PATIENT INFORMATION **Date:**

First Name:_____ Middle name:_____

Last Name:_____ Nickname:_____

Birth Date:_____ Gender: M F

Social Security # (SSN):_____ Marital Status: Minor Single Married

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Email Address: _____ Work Phone: _____

How did you hear about us?_____ Place of Employment:_____

RESPONSIBLE PARTY same as above? YES/ NO- If NO please complete information in this box. If yes skip **this box**

Name:_____ Relationship to Patient:_____

Address: _____ Birth Date: _____

_____ Home Phone:_____

_____ Cell Phone:_____

Social Security # (SSN): _____ Work Phone:_____

E-Mail Address:_____

INSURNACE INFORMATION

PRIMARY DENTAL INSURNACE

Insurance company:_____

Subscriber ID:_____Group #_____

Subscriber Name:_____

Subscriber Birth Date:_____

Subscriber Social Security:_____

Subscriber Employment:_____

Relationship to patient:_____

SECONDARY DENTAL INSURNACE

Insurance Company:_____

Subscriber ID:_____Group#_____

Subscriber Name:_____

Subscriber Birthdate:_____

Subscriber Social Security:_____

Subscriber Employment:_____

Relationship to Patient:_____

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Please check all that apply:

ALLERGY TO:

- ☐ Acrylic
- ☐ Amoxicillin / Penicillin
- ☐ Azithromycin
- ☐ Clindamycin (Cleocin)
- ☐ Valium, Xanax, Ativan
- ☐ Codeine
- ☐ Epinephrine
- ☐ Metals
- ☐ Ibuprofen / Advil

- ☐ Taking Birth Control Pills
- ☐ Artificial/Damaged Heart Valve
- ☐ Heart Malformation / Defect
- ☐ Endocarditis
- ☐ Pulmonary Shunt
- ☐ Mitral Valve Prolapse
- ☐ Artificial Joint
- ☐ Radiation Treatment
- ☐ Heart Disease / Angina
- ☐ Heart Attack
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Taking Blood Thinners

- ☐ Hemophilia
- ☐ Kidney Disease / Dialysis
- ☐ Liver Disease / Cirrhosis
- ☐ Alcohol / Drug Abuse
- ☐ Hepatitis / Jaundice
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Osteoporosis
- ☐ Taken Fosamax, Boniva, Actonel
- ☐ Diabetes
- ☐ Asthma / Emphysema
- ☐ Back Problems
- ☐ Epilepsy / Seizures
- ☐ Ulcers

Please check all that apply:

- ☐ Do your gums bleed while brushing or flossing?
- ☐ Are your teeth sensitive to hot, cold, or sweets?
- ☐ Do you chew / smoke tobacco in any form?
- ☐ Do you notice you clench or grind your teeth?
- ☐ Do you have frequent headaches?
- ☐ Do you have Jaw pain or TMJ?
- ☐ Do you have problems with teeth / fillings breaking?
- ☐ Have you ever had orthodontic / braces treatment?
- ☐ Anorexia / Bulimia
- ☐ Do you have an excessively dry mouth?

- ☐ Are you currently under the care of a Physician?
  If checked, Physician Name:_____
  Physician phone:_____
  If checked, What condition is being treated:

- ☐ Have you had any complications following dental treatment?
  If checked, Please describe:

- ☐ Have you had any serious illness, operation, or hospitalization in last 5 years?
  If checked, Please describe:

MEDICATIONS: please list all medication you are taking here.

To the best of my knowledge, all off the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment.

Patient Signature_____ Date_____

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PATIENT INFORMATION

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PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____

I authorize the personnel of Sanilac Smiles-Dr.Burdua to release all dental information to my family members and friends listed below. We cannot release information to anyone else unless written below.

NAME	RELATION TO PATIENT	PHONE NUMBER
1)		
2)		
3)		

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, it must be in writing and presented to Sanilac Smiles.

Patient signature _____

Relationship to patient or legal guardian_____

Date_____

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PATIENT INFORMATION

FINANCIAL POLICY

Sanilac Smiles Dental Care

Thank you for choosing us to provide your dental care. We place a high priority on the dental health of our patients and our goal is for you to enjoy the benefits of a comfortable, functional and attractive smile. We've found that a clear understanding of our financial policy in advance of your dental care helps relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

Patients with Insurance:

It's important to remember that your insurance coverage is a contract between you and your insurance company. Benefits and coverage can vary significantly from plan to plan. Please keep in mind that insurance is not designed to provide a 100% benefit, but rather is meant to *assist* you with your investment in dental care. *The cost of treatment is your responsibility regardless of your insurance coverage.*

As a courtesy to our patients we are happy to submit claims to your insurance company. In order to do this, you must provide us with accurate and up-to-date insurance information. We will verify your coverage before treatment and we will **ESTIMATE** the portion insurance will cover and your copayment, including deductibles. This co-payment is due on the day of treatment unless other arrangements have been made ahead of time**. *This amount will be an ESTIMATE only, so there may be an additional balance due after payment from your insurance company. You are responsible for any such remaining balance.***

For your convenience we accept cash, checks, Visa, MasterCard, Discover and American Express.

Patients without Insurance:

Payment is expected at the time of service unless prior financial arrangements have been made. As noted above, we accept cash, checks, Visa, MasterCard, Discover and American Express. We also accept Care Credit, which is an outside healthcare financing program that offers several payment plans upon approval.

Discounts:

- Cash Discounts: We offer a 5% discount for payments you make by cash or check.
- Senior discount: We offer a 5% discount to our patients over 65.
- Military/Veterans discount: we are pleased to honor those who have served our country with a 5% discount

Discounts do not apply to patients with insurance or to Orthodontic Treatment including Invisalign

More than one discount can not be combined with any other discount, coupon, or business exclusive pricing such as Smiles Plus

Initial _____

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Returned Check Fees:

The fee for a returned check is $35.00 per occurrence. You will not be allowed to write another check until the full amount (the original amount plus the $35.00 fee) is paid. Another incident may result in losing the privilege of paying by check again.

Minor patients:

If you have a child under the age of 18, please plan to be present at his or her appointment. If you are unable to attend, please call our office prior to the visit to take care of any necessary financial arrangements. In the case of divorced parents, please remember that the parent bringing the minor child is responsible for payment of the child's treatment, regardless of any custodial decrees.

Missed appointments:

We understand that sometimes it is necessary to change your appointments. If you need to reschedule an appointment, please give us at least 48-hour advance notice. Missed appointments are costly for us all and may prevent us from assisting another guest. Please be aware that failed appointments or those cancelled with less than 48-hour notice, may incur in a $50.00 missed appointment fee. A pattern of missed appointments and/or late cancellations may result in dismissal from the practice.

I have read and understand the above conditions and agree to their consent.

_____ _____

Signature of Patient or legally Authorized Representative Date

_____

Printed Name of Patient or Representative

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PATIENT INFORMATION

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights:
When it comes to your health information you have certain rights. The section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your dental record**
  - You can ask to see or get an electronic or paper copy of your dental and other healthy information we have about you. Ask us how to do this
  - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-base fee.
- **Ask us to correct your dental record**
  - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
  - We may say "no" to your request but we will tell you why in writing within 60 days.
- **Request confidential communications**
  - You can ask us to contacts you in a specific way (for example home or office phone) or to send mail to a different address.
  - We will say "yes" to all reasonable request
- **Ask us to limit what we use or share**
  - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why
  - We will include all the disclosures except for those about treatment, payment and heal care operations, and any other disclosures you asked us to make
  - Well provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months
- **Choose someone to act for you**
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information
  - We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated
  - You can file a complaint with the U.S department of Health and Human Service for civil Rights by sending a letter to 200 Independence Ave, S.W., Washington D.C. 20201, by calling 1-877-696-6775 or by visiting www.hhs.gov/ocr/privacy/hippa/complaint/.
  - We will not retaliate against you for filling a complaint

Your Choices:
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations describe below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- You have both the right and the choice to tell us we can:
  - Share information with your family, close friends
  - Share information with other involved in payment for your care
- Unless you give us written permission, we never share your information for marketing purpose or sell your information

Our Uses and Disclosures

Sanilac Smiles Dental Care
Anthony Burdua, DDS

PATIENT INFORMATION

We typically use or share your health information in the following way:

- Treat you
  - We can use your health information and share it with other professionals who are treating you
  - Example: we need to refer you to a specialist for treatment, and may forward information about your condition
- Run our organization
  - We can use and share your information to run our practice, improve your care and contact you when necessary.
  - Example: we use health information about you to manage your treatment and services
- Bill your services
  - We can use and share your health information to bill and get payment from insurance plan or other entities
  - Example: we give information about you to your insurance plan so it will pay for your services

How else can we use or share your health information?

- We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hippa/understanding/consumers/index.html
- Prevent disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Do research
  - We can use or share your information for health research
- Comply with the law
  - We will share information about you if state or federal laws require it, including to the Department of Health and Human Services if it wants to see that were complying with federal policy law.
  - We can share health information with a corner or medical examiner when an individual dies
- Address workers' compensation, law enforcement and other government request
  - We can use or share health information about you for workers' compensation claims
  - We can share health information about you with health oversight agencies for activities authorized by law
- Respond to lawsuits and legal actions
  - We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: ww.hhs.gov/ocr/privacy/hippa/understanding/consumers/noticepp.html

Change to the terms of this notice

We can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our web site.

Effective Date: July 1st 2016

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PATIENT INFORMATION

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

Sanilac Smiles Dental Care
Dr. Anthony Burdua

The health Insurance Portability and Accountability Act (HIPPA) of 1996 requires that health care providers give patients a copy of the offices Notice of Privacy Practices and make good faith effort to obtain an acknowledgement or receipts of the Notice.

You may refuse to sign this acknowledgement form.

By signing this form, I confirm that I have received a copy of this offices Notice of Privacy Practices.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Printed Name of Patient or Representative Relationship to Patient

Office Use Only:

_____ Patient Refused to sign this acknowledgement

_____ Initials of office staff

Reason Patient gave for refusal to sign:_____

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PATIENT INFORMATION

Consent for Dental Treatment of Minor

(Limited Power of Attorney)

I, the undersigned parent or legal guardian of:

_____, A minor do herby authorize and consent to any dental treatment recommended and rendered under the general or special supervision of Anthony Burdua DDS, a duly licensed dentist in the state of Michigan. It is understood that this authorization if given in advance of any specific diagnosis, treatment, or dental care, but is given to provide authority and power to render care which the aforementioned dentist, in the exercise of his best judgement, deems advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any recommended treatment will not be withheld if the undersigned cant not be reached.

This consent shall remain effective until the minor can legally consent for themselves, is discharged from the practice or is revoked in writing by minors' parents or legal guardian.

I authorize, in addition, the following people to present the minor for treatment:

1. Name:_____ relationship to minor:_____
2. Name:_____ relationship to minor:_____
3. Name:_____ relationship to minor:_____
4. Name:_____ relationship to minor:_____

Printed Name of Parent / Legal Guardian:_____

Signature of Parent / Legal Guardian:_____

Date: _____