1 PATIENT INFORMATION

DATE _____

PATIENT_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

SEX M F AGE _____ BIRTHDATE _____

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPERATED ☐ DIVORCE

PATIENT SOC. SEC. # _____

DRIVERS LICENSE #_____

OCCUPATION _____

EMPLOYER _____

EMPLOYER ADDRESS _____

RESPONSIBLE PARTY NAME _____

BIRTHDATE_____SOC. SEC. # _____

EMPLOYER_____

SPOUSE'S NAME_____

WHOM MAY WE THANK FOR REFERING YOU?

_____

2 DENTAL INSURANCE

INSURANCE CO. _____

GROUP # _____

SUBSCRIBER'S NAME _____

BIRTHDATE _____ SOC. SEC # _____

RELATIONSHIP TO PATIENT _____

IS PATIENT COVERED BY ADDITIONAL INS.? Y ☐ N ☐

INSURANCE CO. _____

GROUP # _____

SUBSCRIBER'S NAME _____

BIRTHDATE _____ SOC. SEC. # _____

RELATIONSHIP TO PATIENT _____

ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

I AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

SIGNATURE_____ DATE _____

3 PHONE NUMBERS

HOME _____ WORK _____ EXT _____ SPOUSE'S WORK _____

BEST TIME AND PLACE TO REACH YOU _____

IN CASE OF EMERGENCY, CONTACT (SPECIFY SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD)

NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK PHONE _____

4 DENTAL HISTORY

REASON FOR TODAY'S VISIT _____

FORMER DENTIST _____ ADDRESS _____

PLEASE CHECK (✓) ALL THAT APPLY:

☐ BAD BREATH	☐ GRINDING TEETH	☐ SENSITIVITY TO COLD
☐ BLEEDING GUMS	☐ LOOSE TEETH	☐ SENSITIVITY TO HOT
☐ BROKEN FILLINGS	☐ ORTHODONTIC THERAPY	☐ SENSITIVITY TO SWEETS
☐ CLICKING OR POPPING JAW	☐ PERIODONTAL TREATMENT	☐ SORES OR GROWTHS IN YOUR MOUTH

*** PLEASE COMPLETE BOTH SIDES ***

5 HEALTH HISTORY

PHYSICIAN'S NAME _____ PHONE # _____ LAST VISIT _____

(WOMAN) ARE YOU PREGNANT ☐ YES ☐ NO NURSING ☐ YES ☐ NO TAKING BIRTH CONTROL PILLS ☐ YES ☐ NO

CHECK (✓) IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

☐ AIDS	☐ CORTISONE TREATMENTS	☐ HEPATITIS	☐ RADIATION TREATMENT
☐ ANEMIA	☐ COUGH, PERSISTANT	☐ HIGH BLOOD PRESSURE	☐ RHEUMATIC FEVER
☐ ARTHRITIS	☐ DIABETES	☐ HIV POSITIVE	☐ SCARLET FEVER
☐ ARTIFICIAL HEART VALVES	☐ EPILEPSY	☐ JAW PAIN	☐ SHORTNESS OF BREATH
☐ ARTIFICIAL JOINTS	☐ EXCESSIVE BLEEDING	☐ KIDNEY DISEASE	☐ SKIN RASH
☐ ASTHMA	☐ FAINTING	☐ LIVER DISEASE	☐ STROKE
☐ BACK PROBLEMS	☐ GLAUCOMA	☐ MITRAL VALVE PROLAPES	☐ THYROID PROBLEMS
☐ BLOOD TRANSFUSION	☐ HEART MURMUR	☐ NERVOUS PROBLEMS	☐ TOBACCO HABIT
☐ CANCER	☐ HEART PROBLEMS	☐ PACEMAKER	☐ TUBERCULOSIS
☐ CHEMICAL DEPENDENCY	DESCRIBE_____	☐ PHEN PHEN DIET	☐ ULCERS
☐ CHEMOTHERAPY	☐ HEMOPHILIA	☐ PSYCHIATRIC CARE	☐ VENEREAL DISEASE

ANY OTHER MEDICAL CONDITION WE SHOULD BE AWARE OF? _____

MEDICATIONS

LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

_____ _____

_____ _____

_____ _____

ALLERGIES

CHECK (✓) ALL THAT APPLY:

☐ ASPIRIN ☐ LOCAL ANESTHETIC

☐ CODEINE ☐ PENICILLIN

☐ LATEX ☐ OTHER _____

6 SIGNATURE AND UPDATES (SIGN ONLY ONCE)

I UNDERSTAND THIS QUESTIONAIRE AND HAVE COMPLETED IT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____ PROVIDER INITIAL _____

SIGNATURE _____ DATE _____ PROVIDER INITIAL _____

SIGNATURE _____ DATE _____ PROVIDER INITIAL _____

SIGNATURE _____ DATE _____ PROVIDER INITIAL _____

SIGNATURE _____ DATE _____ PROVIDER INITIAL _____

SIGNATURE _____ DATE _____ PROVIDER INITIAL _____

OFFICE USE ONLY

DOCTOR	MEDICAL MESSAGE NUMBER
	1 NO MESSAGE **2** SEE MEDICAL HISTORY **3** PREMEDICATE **4** ALLERGIES

WOLFSON DENTAL
COSMETIC & FAMILY DENTISTRY

26601 Coolidge Highway Oak Park, MI 48237 P:(248) 352-2266 F: (248) 352-2267

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Wolfson Dental for your dental needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance.
- Patients are responsibly for payments of co-pays, co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Payment and co-pays are due at the time of service, and for your convenience we accept cash, check and most major credit cards at our office.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for missed/broken appointments without 24 hours notice
    - Charge for the copying and distribution of patient dental records
    - Charge for the copying and distribution of patient x-rays
    - Any cost associated with collection of a patient balance
    - Charge for returned checks

By my signature below, I hereby authorize assignment of financial benefits directly to Wolfson Dental for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name _____

Patient/Guardian Signature_____

Date_____

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____

Patient Signature Patient Name (please print)

Date: _____

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgment:

_____

An emergency situation prevented the patient from signing the Acknowledgement.

_____ _____

Office Personnel (signature) Office Personnel (print name)

Date: _____

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____

Patient Signature Patient Name (please print)

Date: _____

READ ONLY

Dr. Mark Wolfson 26601 Coolidge Hwy Oak Park, MI 48237 P(248) 352-2266 F(248) 352-2267

NOTICE OF PRIVACY PRACTICES

Effective date of notice: 01/01/2017

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it. PLEASE REVIEW IT CAREFULLY.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will ask you for special written permission, but may accept verbal permission in some situations.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are: when a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes; disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; uses and disclosures for health oversight activities; for audits; disclosures for judicial and administrative proceedings; disclosures for law enforcement purposes; to provide information about a crime at our office; or to report a crime that happened somewhere else; disclosure to a medical examiner; or to organizations that handle organ or tissue donations; uses or disclosures for health related research; uses and disclosures to prevent a serious threat to health or safety; uses or disclosures for specialized government functions; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service; disclosures of de-identified information; disclosures relating to worker's compensation programs; disclosures of a "limited data set" for research, public health, or health care operations; incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends to the extent necessary to help with your healthcare or payment for your healthcare.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. **Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.**
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office at the address, fax number, or e-mail shown at the beginning of this Notice.

READ ONLY

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office at the address, fax number, or e-mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office at the address, fax number, or e-mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance, a fee of $25.00. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office at the address, fax number, or e-mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office at the address, fax number, or e-mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office at the address, fax number, or e-mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office at the address, fax number, or e-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office at the address, fax number, or e-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this Notice.