Symptom Screening

Patient Name:_____ Date: _____

Are you experiencing any of the following symptoms?

- ☐ Fever, chills, sweating
- ☐ New or worsening cough
- ☐ Fatigue
- ☐ Body aches
- ☐ Diarrhea
- ☐ Reduced sense of smell and/or taste
- ☐ Mild to moderate difficulty breathing
- ☐ Sore throat
- ☐ Runny nose
- ☐ None of the above

If yes to any, what do you contribute these symptoms to?

_____

Are you taking any fever reducing medications?

☐ YES What, when and why? _____

☐ NO

In the last 14 days, have you been around someone who is known to have COVID-19, or anyone who is having symptoms?

☐YES explain: _____

☐NO

For both vaccinated and non-vaccinated persons, if you have been exposed to Covid you must wear a mask in public for 10 days. Since you must remove your mask during treatment in our office, your appointment would have to be postponed until the 10 days have passed.

Thank you for your understanding and cooperation.

Patient Signature:_____ Date: _____

TIME 01:56 PM DATE 2/20/2023

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

Emergency Contact:

Contact Phone:

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:

VANBUSKIRK DENTAL

MEDICAL HISTORY

Patient Name:_____ Birthdate:_____

Are you under a physician's care now? ☐ Yes ☐ No

If yes please explain:_____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes for what and when?_____

Do you have any artificial joints? ☐ Yes ☐ No

If yes, when and by whom? _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

If yes please explain: _____

Are you taking any medications, pill, or drugs? ☐ Yes ☐ No

If yes please list or attach a copy: _____

Have you ever taken Fosamaz, Boniva, Actonel or any other medications containing biophosphonates? ☐ Yes ☐ No

If yes: _____

Are you on a special diet? ☐ Yes ☐ No

If yes: _____

Do you use tobacco? ☐ Yes ☐ No

If yes: _____

Do you use controlled substances? ☐ Yes ☐ No

If yes: _____

Do you require pre-medications before dental visits? ☐ 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 ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other? _____

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

AIDS/HIV Positive	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chest pains	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Yellow Jaundice	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Easily Wounded	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes: _____

Comments:

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: _____

Dental Questionnaire

Name: _____ Date: _____

1. What is the primary reason for your visit?

   _____

2. What is the date of your last dental visit? _____

3. What is the date of your last dental checkup and cleaning? _____

4. What is the name and address of your previous dentist?

   _____

5. Are your teeth sensitive to any of the following?

   ☐ Hot/Cold
   ☐ Sweets
   ☐ Chewing
   ☐ None of the above

6. Do your gums bleed or hurt? ☐ Yes ☐ No

7. Are you satisfied with the appearance of your teeth/smile? ☐ Yes ☐ No

8. Do you feel nervous about having dental treatment? ☐ Yes ☐ No

   If yes, what is your biggest concern?

   _____

SLEEP SCREENING QUESTIONNAIRE

Patient Name:_____ Date:_____ DOB: _____

In accordance with recommendations from the American Sleep Association, we are screening all patients for potential sleep disorders including Sleep Apnea. Sleep Apnea is a serious condition where patients stop breathing multiple times in their sleep. This can lead to major health problems like hypertension, diabetes, heart attack, stroke and cancer and goes 90% undiagnosed. Please complete the Patient Survey section and the doctor will review the evaluation with you today.

Patient Survey:

Has anyone ever told you that you snore?	☐ Yes ☐No	Do you have a history of depression?	☐Yes ☐No
Do you feel excessively tired during the day?	☐ Yes ☐No	Do you have a history of stroke/heart disease?	☐Yes ☐No
Do you wake up choking or gasping?	☐Yes ☐No	Do you have a history of GERD (Acid Reflux)	☐Yes ☐No
Have you ever been told that you stop breathing while you sleep?	☐Yes ☐No	Have you ever been diagnosed with a sleep disorder?	☐Yes ☐No
Do you have a family history of snoring or sleep apnea?	☐Yes ☐No	-If yes, are you currently using a CPAP machine?	☐Yes ☐No
Do you have a history of hypertension?	☐Yes ☐No	-How often do you use it? _____	
Do you have a history of diabetes?	☐Yes ☐No	-Would you prefer an oral appliance over a CPAP machine?	☐Yes ☐No

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations?
Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze **1 = Slight chance of dozing** **2 = moderate chance of dozing** **3 = High chance of dozing**

SITUATION	
Sitting and reading	_____
Watching Television	_____
Sitting inactive in a public place (i.e. theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped in traffic for a few minutes	_____
TOTAL SCORE	☐

A score of 8 or greater indicates the possibility of sleep disordered breathing.

THORNTON SNORING SCALE

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her, both physically and emotionally. Use the following scale to choose the most appropriate number for each situation. (Go to the 4th statement if you have no bed partner.)

0 = Never **1 = Infrequently (1 night per week)** **2 = Frequently (2-3 nights per week)** **3 = Most of the time (4 or more nights per week)**

My snoring affects my relationship with my partner	_____
My snoring requires us to sleep in separate rooms	_____
My snoring is loud	_____
My snoring affects people when I am sleeping away from Home (i.e. hotel, camping, etc.)	_____
TOTAL SCORE	☐

A score of 5 or greater indicates your snoring may be significantly affecting your quality of life.

Examination: (office use only)

Male ☐ Female ☐ Height _____ Weight _____ Blood Pressure: _____ Pulse: _____ Neck Size: _____

Bruxism ☐ Large Tongue ☐ Large Tonsils ☐ Overbite ☐ Retruded jaw ☐

Impression:

☐ Recommend Evaluation with Sleep Specialist
☐ Recommend Snore Appliance Only
☐ Signs/Symptoms do not warrant need for further follow up/treatment

_____
Doctor Signature

Comments:

_____

_____

_____

Consent to Electronic Communications

Patient Name _____ Date of Birth _____

I consent that Brittany VanBuskirk, DDS, PLLC (The Company) and their agents can communicate with me via telephone, text message, e-mail and any type of online communications directly or by using an automatic telephone dialing system, interactive voice system, or artificial or prerecorded voice or message, provided that these communications comply with privacy regulations.

Appointment Reminders

I understand that The Company can reach me to remind me of my appointments, to let me know if there is a change to an appointment, or when I am due to schedule an appointment. I also understand that The Company may employ and use a third-party automated system to contact me regarding my appointments.

Telemedicine Appointments

For telemedicine, I understand the appointments will be held via electronic environments.

Billing and Payment Reminders

I understand that The Company or it's agents may contact me electronically regarding any outstanding balance I may have, to request payment or to notify me of account delinquency. I also understand that The Company may employ or use a third-party automated system to notify me of my account balance.

Contact Information Change

I accept that I am responsible of notifying The Company when my contact information changes.

Consent Cancellation

I understand that I can revoke my consent at any time by contacting The Company.

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: _____

Financial Policy & Consent

VANBUSKIRK DENTAL
5895 John R
Troy, MI 48085
(248) 828-8128

Treatment Recommendations: Treatment recommendations are based on your individual needs. Fees are not typically explained prior to rendering treatment. When you accept treatment in our office, you are accepting responsibility for the cost of all services rendered on your behalf or that of your dependents regardless of expected insurance coverage or of your unawareness of the fees involved. If you would like to review the fees, please ask to speak to our Financial Coordinator prior to starting treatment.

Payment Policy: Payment for services is due at the time the service is rendered. If you have dental insurance, the estimated amount of coverage can be deducted from your payment at the time of service. We accept cash, checks, and major credit cards. On treatment requiring multiple appointments, you may choose to pay a minimum of 50% at the initial appointment and the remainder of the balance upon timely completion. If treatment is suspended, delayed or terminated, the full remaining balance, including any estimated insurance portion, will become due immediately.

Credit Policy: In order to extend credit in our office, you must have established credit history with us or give us permission to run a credit report. With approved credit, we offer a wide variety of both in-office payment arrangements, and third-party interest-free financing, for balances exceeding $200.00. Please ask to speak to our Financial Coordinator with any question regarding your dental investment or to apply for credit.

Dental Insurance: Dental Insurance is a contract between you and your insurance company that is designed to assist with a portion of dental treatment costs. We are not party to this contract in most cases. Most often, services are NOT covered in full and there may be limitations of which this dental office is not liable. As a courtesy to you, we are happy to file the forms necessary to assure you receive the full benefit of your dental insurance, and we gladly accept direct payment from most insurance companies. However, you are ultimately responsible for all charges that your insurance company does not cover. Although we may estimate what your insurance company will pay, it is the insurance company that makes the final determination of your eligibility and coverage once a claim is filed. Therefore, the amount due our office is subject to change once the insurance payment is received. It is important that you inform yourself of the full extent of your insurance benefits. If your insurance company does not respond within 60 days, the remaining balance will become your responsibility.

Worker's Compensation, Auto Insurance and Personal Injury Claims: We will gladly process your insurance or lawsuit claim and forward any necessary records as you request, however, payment of the bill remains the patient's responsibility. Payment is expected at the time of service, we will request the insurance carrier send their payment directly to you.

Monthly Statements: Monthly statements will be sent for any patient balance remaining on your account. The balance on your statement is due by the date shown on the statement. Finance charges will apply if payment is not received by the due date.

Finance Charge: Unless other arrangements have been established in writing, a finance charge will be imposed on each item of your account which has not been paid within 30 days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and a quarter percent (1.25%) per month or an **ANNUAL PERCENTAGE RATE** of fifteen percent (15%). The finance charge on your account is computed by applying the periodic rate (1.25%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.60.

Returned Checks: There is a fee for any check returned by the bank. Upon receiving the returned check, our office will attempt to contact the financial institution to verify funds. If funds have become available, we will redeposit the check and bill you for the returned check fee. If funds are still not available, our office will notify you by phone or in writing. If the amount due is not paid with cash within seven business days of receipt of notice, it will be considered as intent to defraud and may be reported to the Troy Police Department.

(This policy continues on the back side of this form)

Missed Appointment Fee: The second time a patient does not show up for an appointment, or cancels with less than 24-hour notice, a fee may be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another doctor.

Past Due Accounts: We will make several attempts to contact you if your account becomes past due. If we are unable to reach you, if you have expressed an unwillingness to pay, or if your balance becomes 120 days overdue, your account will become delinquent. If your account becomes delinquent, we will take necessary steps to collect this debt. We have the option to report your account status to any credit reporting agency such as a credit bureau. If collection efforts are required, you shall be liable for all cost of collection, including reasonable attorney's fees. If your account is referred to an outside collection agency, a collection fee will be added to your account. In case of suit, you agree the venue shall be in Oakland County, Michigan.

Waiver of Confidentiality: You understand that if this account is submitted to an attorney, collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment in our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, which may include your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, which may include your payment history.

Consent

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, scans, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my or my dependent's dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

4. I understand that even with dental insurance, I am ultimately responsible for all charges. I understand that any insurance coverage information provided to me by a member of this staff is not a guarantee of coverage.

5. I understand and agree to all the terms of this Financial Policy, and I agree to be responsible for payment of all services and charges rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made in advance. If payments are not received by agreed upon dates, I understand a finance charge (15% APR) may be added to my account.

Patients Name: _____

Name of Responsible Party (if different from patient): _____

Signature of Responsible Party: _____ **Date:** _____