WELCOME
TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your dental care needs.

PATIENT INFORMATION

Today's Date _____ Birth Date _____ Patient Social Security # _____

Patient Name _____
(Last Name) (First Name) (Initial)

Street Address _____

City _____ State _____ Zip _____

Occupation _____ ❒ Male ❒ Female ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Separated

Patient Home Phone _____ Patient Work Phone _____

Employer _____ Employer Phone _____

Employer Address _____

In Case Of Emergency Contact:

Name _____ Relationship _____

Emergency Home Phone _____ Emergency Work Phone _____

Whom may we thank for referring you to us? _____

PRIMARY INSURANCE

Individual responsible for this account _____
(Last Name) (First Name) (Initial)

Relationship to Patient _____ Birth Date _____ Social Security # _____

Street Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Individual's Name _____
(Last Name) (First Name) (Initial)

Relationship to Patient _____ Birth Date _____ Social Security # _____

Street Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Party Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, for any services provided me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original. In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here. I expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim submitted.

Signature _____ Date _____

FAMILY HEALTH INFORMATION

Some health conditions are the result of hereditary spinal weaknesses. Information that you can furnish us pertaining to your immediate family members (brothers, sisters, parents and grandparents) will give us a better understanding of your total health needs.

RELATIONSHIP TO YOU	HEALTH PROBLEMS ANY FAMILY MEMBER HAS HAD OR HAS NOW

MEDICATIONS

List medications you are currently taking

_____

_____

_____

_____

Pharmacy _____ Phone _____

- ❑ Aspirin
- ❑ Barbiturates
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other (please list)

_____

_____

_____

CHECK ANY SYMPTOM(S) OR CONDITION(S) BELOW THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR:

- ❑ AIDS
- ❑ Appendicitis
- ❑ Arm Pain or Numbness
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain or Numbness
- ❑ Bleeding Disorders
- ❑ Bleeding Gums
- ❑ Bloating
- ❑ Blood in Urine
- ❑ Blurred Vision
- ❑ Bowel Changes
- ❑ Breast Lump
- ❑ Brights Disease
- ❑ Bruise Easily
- ❑ Bursitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Change in Moles
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Chicken Pox
- ❑ Chills
- ❑ Constipation
- ❑ Crossed Eyes
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Depression/Nervousness
- ❑ Difficulty Swallowing
- ❑ Dizziness/Fainting
- ❑ Double Vision
- ❑ Excessive Thirst
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Earache
- ❑ Ear Discharge
- ❑ Feet Pain or Numbness
- ❑ Fever
- ❑ Forgetfulness
- ❑ Frequent Urination
- ❑ Gas
- ❑ Glaucoma
- ❑ Hand Pain or Numbness
- ❑ Hay Fever
- ❑ Headache
- ❑ Heart Disease
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hip Pain or Numbness
- ❑ HIV Positive
- ❑ Hives
- ❑ Hoarseness
- ❑ Indigestion
- ❑ Irregular Heartbeat
- ❑ Itching
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Lack of Bladder Control
- ❑ Leg Pain or Numbness
- ❑ Liver Disease
- ❑ Loss of Hearing
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Low Blood Pressure
- ❑ Lumbago
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nausea
- ❑ Neck Pain or Numbness
- ❑ Neuralgia
- ❑ Neuritis
- ❑ Nose Bleeds
- ❑ Pacemaker
- ❑ Painful Urination
- ❑ Persistent Cough
- ❑ Pneumonia
- ❑ Polio
- ❑ Poor Appetite
- ❑ Poor Circulation
- ❑ Prostate Problem
- ❑ Rapid Heartbeat
- ❑ Rash
- ❑ Rectal Bleeding
- ❑ Rheumatic Fever
- ❑ Ringing in Ears
- ❑ Scarlet Fever
- ❑ Scars
- ❑ Sciatica
- ❑ Shoulder Pain or Numbness
- ❑ Sinus Problems
- ❑ Sore That Won't Heal
- ❑ Stomach Aches or Pains
- ❑ Stroke
- ❑ Sweats
- ❑ Swelling Ankles
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Vision Flashes
- ❑ Vomiting
- ❑ Vomiting Blood

CHECK DEGREE OF HABITS BELOW. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

	HEAVY	CASUAL	LIGHT	NONE
Alcohol	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑
Coffee	❑	❑	❑	❑

	HEAVY	CASUAL	LIGHT	NONE
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sleep	❑	❑	❑	❑

	HEAVY	CASUAL	LIGHT	NONE
Soft Drinks	❑	❑	❑	❑
Sugar/Sugar Products	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Water	❑	❑	❑	❑

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

DARNELL KAIGLER, D.D.S., M.S., PH.D
2671 W. GRAND BOULEVARD
DETROIT, MI 48208
TEL: (313) 871-0436

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____