Clio Family Dentistry

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4279 W. Vienna • Clio, MI 48420 (810)687-2000

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

How did you hear about our practice, or whom may we thank for referring you?

Referral Name: _____

☐ Friend ☐ Location ☐ Google ☐ Facebook ☐ Online-Other ☐ Insurance

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or if patient is under 18.

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Authorization:

☐ * **By initialing this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic 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 financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Medical History

Do you have any allergies, if so please list them:

Can you provide an up to date list of your current medications including any supplements or vitamins?

Please list any recent surgeries or hospitalizations.

Do you have high blood pressure or hypertension?

Are you a Diabetic, and if so what was your most recent HbA1c test score?

Are you taking any blood thinners, and if so which ones?

Do you have any disorders of the liver including but not limited to: Hepatitis, Liver Disease, Cirrhosis?

Have you been diagnosed with any autoimmune diseases such as Lupus, HIV/AIDS, MS, Sjogren's Syndrome?

Do you have any disease of your blood? This includes Leukemia, Clotting Disorders, Anemias.

Any history of Cardiovascular Disease, Heart Disease, Heart Failure, or Stroke?

Have you had cancer, treatment for cancer, chemotherapy, or radiation to your head and to your neck?

Have you ever taken, or are you taking bone strengthening medications such as Bisphosphonates or Fosamax?

Do you have any artifical heart valves, pacemakers, or heart murmurs?

Do you have any artificial joints or have you had joint replacement surgery?

Are you required to take an antibiotic before dental treatment?

Do you smoke, vape, or consume nicotine? If yes, how often and how much?

Do you consume alcohol? Daily? Weekly? On occasion? Never?

Do you use recreational drugs? If so please explain.

Are you pregnant or nursing?

Do you experience acid reflux, indigestion, or GERD?

Do you have Sleep Apnea, or are you being treated for Sleep Apnea?

Do you feel like you clench and grind your teeth? Have you been treated for TMJ or TMD in the past?

Do you experience headaches, migraines, facial muscle pain, or trigeminal neuralgia? If so how often?

Did you have orthodontics, braces, or invisalign in the past?

Have you ever been diagnosed or treated for periodontal disease or gum disease?

When is the last time you had dental X-rays?

Are there any medical conditions not covered on this list that you feel you need to report?

Please provide your preferred pharmacy name and phone number:

Emergency contact name, relation, and phone number:

☐ * **By initialing this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire. There are no other medical conditions or medications/allergies that have not been listed. I will notify of any changes.**

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By initialing this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Cancellation Policy

We appreciate and respect the time of our patient. Therefore, this practice does ask for a minimum of 48 hour notice for any cancellations or changes to our schedule. We reserve the right to charge $50.00 per appointment if this policy is not adhered to. We specially reserve time for each patient. We do however, know that illness and emergencies occur and we do accommodate those rare instances. Thank you for choosing Clio Family Dentistry.

☐ * **By initialing this box, I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or Healthcare operations.
By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:
_____
_____

I acknowledge that I understand all health questions and contents in the previous forms. I have completed all questions to my best ability and will comply with the office policies stated.

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____Date: _____

Dentist Signature: _____ Date: _____

RESTORATIVE CONSENT ACKNOWLEDGEMENT

I understand that my **DIET AND HYGIENE** will influence the longevity of dental filling. If decay forms around filling, the may need replacement or more extensive treatment. Such treatment may or may not be covered by my dental insurance. Regular check-ups and cleanings are recommended so we can monitor restorations accordingly.

Signature _____ Date_____



Dr. Thomas Pascoe
4279 W. Vienna Rd
Clio, MI 48420
810-687-2000

Office Policy

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1. Full payment is due at the time of service, unless payment arrangements are made in advance with our office.
2. Our office accepts Cash, Check, Visa, MasterCard, Discover and Care Credit.
3. If you want your treatment to be predetermined, please let us know. A predetermination from your insurance company may take 4-6 weeks and is not a guarantee of payment.
4. Clio Family Dentistry requires a minimum of 48 hours' notice for appointment cancellations or changes. If you break a scheduled appointment without prior notice, we reserve the right to charge you $50 for time lost.
5. As a courtesy, our office will be happy to bill your insurance for you. Your dental insurance is a contract between your employer and your dental benefit company. It is your responsibility to keep track of your individual dental benefits and limitations.
6. We do not base your treatment needs on your insurance benefits or limitations. If your insurance does not pay what we have anticipated or estimated, any difference is your responsibility and will be billed to you.

I agree to accept financial responsibility for my treatment. In addition, I authorize my dental insurance benefits to be paid to Clio Family Dentistry. I also authorize Clio Family Dentistry to release dental record copies and confidential dental histories pertaining to my treatment when necessary to insurance companies and/or other health care providers.

Signature:_____Date:_____