Chart #: _____

For Office Use Only

Patient Name:_____
Last First Middle

□ Male □ Female □ Married □ Single □ Child □ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext. _____

Best Time to Call:_____

Preferred Appointment Time: □ Morning □ Afternoon □ Evening □ Any Time □ M □ T □ W □ T □ F □ S

Address:_____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply.

- □ AIDS
- □ Allergies: _____ _____
- □ Anemia
- □ Arthritis
- □ Artificial Joints
- □ Asthma
- □ Blood Disease
- □ Cancer
- □ Diabetes
- □ Dizziness
- □ Epilepsy
- □ Excessive Bleeding
- □ Fainting
- □ Glaucoma
- □ Growths
- □ Hay Fever
- □ Head Injuries
- □ Heart Disease
- □ Heart Murmur
- □ Hepatitis
- □ High Blood Pressure
- □ Jaundice
- □ Kidney Disease
- □ Liver Disease
- □ Mental Disorders
- □ Nervous Disorders
- □ Pacemaker
- □ Pregnancy
  Due Date: _____
- □ Radiation Treatment
- □ Respiratory Problems
- □ Rheumatic Fever
- □ Rheumatism
- □ Sinus Problems
- □ Stomach Problems
- □ Stroke
- □ Tuberculosis
- □ Tumors
- □ Ulcers
- □ Venereal Disease
- □ Codeine Allergy
- □ Penicillin Allergy

OTHER:

- □ _____
- □ _____

Have you ever had any complications following dental treatment? □ Yes □ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No
If yes, please explain: _____

Are you now under the care of a physician? □ Yes □ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? □ Yes □ No
If yes, please explain: _____

_____Date:_____
Signature of patient, parent, or guardian

Referral Information

Whom may we thank for referring you to our practice? □ Another patient, friend □ Another patient, relative

□ Dental Office □ Yellow Pages □ Newspaper □ School □ Work □ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: □ The patient's spouse □ The person responsible for payment

Name:_____
Last First Middle

□ Male □ Female □ Married □ Single □ Child □ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext. _____

Best Time to Call:_____

Preferred Appointment Time: □ Morning □ Afternoon □ Evening □ Any Time □ M □ T □ W □ T □ F □ S

Address:_____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured:_____ Is insured a patient? □ Yes □ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Address: _____

_____

Employment Information

The following is for: □ The patient □ The person responsible for payment

Employer Name: _____ Occupation: _____

Address:_____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? □ Yes □ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? □ Yes □ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Plan Name and Address: _____

_____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other: _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your 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 and 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.

Patients who carry dental insurance understand that all dental services furnished 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 such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged by all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. 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 shall be instituted hereunder. I also agree to pay any and all collection costs if my account is turned over to a collection agency.

I grant my permission to you or your assignee, to telephone me at my home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent, or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Louis A. Shaheen, D.D.S., PLC
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____
Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time, by contacting:

Contact Person: Office Manager
Telephone: 810-687-3010
Address: P.O. Box 247, Mt. Morris, MI, 48458

Right to Revoke: You will have the right to revoke this consent at any time by giving us written Notice of your revocation submitted to the Contact Person written above. Please understand that Revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature
I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of your protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Name: _____
Phone: _____ Cell: _____
E-Mail: _____

Please check:

- ☐ I would like to receive text message reminders.
- ☐ I would like to receive e-mail reminders.
- ☐ I do not text or e-mail.

Signed: _____