



Patient Profile

First Name _____ Last Name _____ Pref. Name _____
Date of Birth _____ Age _____ Soc. Sec. # _____
Gender _____ Marital Status _____ Previous Dentist _____
Home Address _____
City _____ State _____ Zip Code _____
Home # _____ Cell # _____
Work # _____ Ext _____ Occupation _____
Email _____ Emergency Contact _____
Phone # _____ Relationship to Patient _____

Appointment Preference

How do you prefer to be reached: Home # Cell # Text to Cell # Work # Email
My preferred appointment times are: Morning Afternoons Evenings No Preference

Referral Profile

How did you hear about our office? _____

Insurance Profile

Name of Insured _____ Relationship to Patient Self Spouse Child Other
Insured Soc. Sec. # _____ Date of Birth _____
Employer _____ Insurance Company _____
Insurance ID # _____ Group # _____



Medical History

Patient Name _____ Date of Birth _____

Name of Physician _____ Date Last Physical Exam _____

- Have you ever been hospitalized or had a major injury? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Do you take, or have taken, Phen-Fed or Redux? Yes No If yes, please explain: _____
- Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes No If yes, please explain: _____
- Do you use tobacco? Yes No If yes, please explain: _____

Are you allergic to any of the following?

- Aspirin, Motrin, Tylenol Penicillin Codeine Local Anesthetics Acrylic Metal Latex
- Other: If yes, please explain _____

Women, are you:

- Pregnant/Trying to get pregnant? Yes No
- Taking oral contraceptives? Yes No
- Nursing? Yes No

Do you have or have had any of the following?

- | | | | | | | | |
|-----------------------------|--|------------------------|--|------------------------|--|---------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | COPD / Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Heart Disease | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Depression | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis (Type _____) | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Herpes | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Digestive Disorders | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Angina/Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Sleep Apnea | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy / Seizures | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Bleeding Problems | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Gastric Reflux (GERD) | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores / Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack / Failure | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |
| Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No | Weight Gain/Loss | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Please List all medications, supplements, and vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The questions on this form have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Guardian: _____ Date _____



Dental History

What is your immediate concern? _____

Previous Dentist _____ How Long Were You a Patient _____ Months / Years

I Routinely Saw My Dentist Every: 3 months 4 months 6 months 12 months Not Routinely

Please check off all the things that would keep you from pursuing your dental treatment:

Cost Fear Lack of Time Lack of Importance Other _____

Please answer the following questions so that we may get to know you better:

PERSONAL HISTORY

- Have you ever had an unfavorable dental experience? Yes No
- Have you ever had complications from past dental treatment? Yes No
- Have you ever had trouble getting numb in the past? Yes No

SMILE CHARACTERISTICS

- Are you self-conscious about the appearance of your teeth? Yes No
- Would you like your teeth to look whiter? Yes No
- Have you ever had orthodontics in the past? Yes No
- Do you like the shape of your teeth? Yes No
- Are you happy with the appearance of your lips? Yes No
- Are you interested in Botox and/or Juve'Derm? Yes No

BITE AND JAW JOINT

- Have your teeth become shorter, thin, worn in the last 5 years? Yes No
- Do you have problems with your jaw joint? Yes No
- Do you or have you ever worn a bite appliance? Yes No

TOOTH STRUCTURE

- Have you ever had a toothache, cracked filling, or broken tooth? Yes No
- Are any teeth sensitive to hot, cold, biting, or sweets? Yes No
- Do you avoid brushing any part of your mouth? Yes No
- Do you have a dry mouth? Yes No
- Have you ever had a tooth extracted? Yes No

GUM AND BONE

- Have you ever been diagnosed or treated for periodontal (gum) disease? Yes No
- Is there anyone in your family with a history of periodontal disease? Yes No
- Have you ever experienced gum recession? Yes No
- Do your gums bleed when brushing, flossing, or eating? Yes No
- Have you ever noticed an unpleasant taste or odor in your mouth? Yes No

Signature of Patient or Guardian: _____ Date _____

600 N. Woodward Avenue, Suite 201
Birmingham, Michigan 48009
248.646.0442



HIPAA Authorization

I, (Patient Name or Legal Guardian) _____, authorize the practice of Dr. DiPilla and its staff to provide medical treatment and to release information related to patient treatment, payment, or health care operations.

I further acknowledge receipt of this practice's Notice of Privacy Practices and rights to review the Provider's Privacy Requirements.

Signature of Patient or Legal Guardian _____ Date _____

Office Policies

At our office we believe in devoting our entire focus towards each patient. Please understand for this to happen we specifically reserve time in the schedule for your treatment needs. Due to the high demand for these appointment slots, the following office policies have been instituted:

THERE WILL BE A \$50 FEE CHARGED TO YOUR ACCOUNT IF YOU FAIL TO MAKE YOUR HYGIENE APPOINTMENT OR DO NOT CALL THE OFFICE WITHIN A 24 HOUR PERIOD TO CANCEL.

IF YOU HAVE RESERVED TIME WITH DR. DIPILLA, THE FEE WILL BE ASSESSED BASED ON YOUR TREATMENT PLAN AND THE LENGTH OF THE APPOINTED TIME MISSED.

IF YOU ARE MORE THAN 15 MINUTES LATE FOR YOUR APPOINTMENT AND WE ARE UNABLE TO PERFORM THE PLANNED TREATMENT IN THE TIME REMAINING, WE WILL NEED TO RESCHEDULE YOUR APPOINTMENT.

Our staff wants to be available for your needs and the needs of all our patients, however, when a patient does not show up for a scheduled appointment, another patient misses the opportunity to be seen.

We thank you for being a valued patient and for your understanding of these office policies.

Signature of Patient or Guardian: _____ Date _____



Our Financial Policy

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Regarding Insurance

You are responsible for payment of all services rendered. Payment in full is required at the time of service. We may accept assignment of your insurance benefits, but please understand your insurance policy is a contract between you and your insurance company. We have no influence in the terms agreed upon between you and your insurance company. We are happy to submit your insurance claim but we will need all of your insurance information. Failure to do so prohibits any claim submission and the entire balance will be due immediately. If a portion of your treatment will be covered by your insurance, we require your co-pay portion to be paid at the time of service. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. The balance is your responsibility whether your insurance company pays or not. Please be aware some of the services provided may be non-covered services by the Insurance Program and/or other medical insurance. This is not a statement by the insurance company that the service was unnecessary, but rather a reason for rejection of payment by the insurance company.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Guardian: _____ Date _____

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