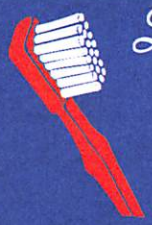
WELCOME!

7305 E M-36
WHITMORE LAKE
48189



Lakeview DENTAL CARE
810-231-2288
Dr. Jeffrey Brink
www.smilelakeview.com

PHONE: 810-231-2288
FAX: 810-231-3843

ABOUT YOU

Name: _____
I prefer to be called: _____
Birthdate: ____/____/____ *SSN:* _____
Address: _____
_____
Home # (___)_____ *Cell #* (___)_____
Work # (___)_____ *Email* _____

Employer _____
Occupation _____
Hobbies _____
Previous Dentist _____
Date of last dental visit _____

How did you hear about our office?
_____

PRIMARY INSURANCE

Insurance company name _____
Insurance company phone number _____
Group # _____
Insured's name _____
Insured's DOB ___/___/___ *SSN* _____
Insured's employer _____

SECONDARY INSURANCE

Insurance company name _____
Insurance company phone number _____
Group # _____
Insured's name _____
Insured's DOB ___/___/___ *SSN* _____
Insured's employer _____

FAMILY INFORMATION

Spouse's name _____
Spouse's DOB ___/___/___

Child's name _____
Child's DOB ___/___/___

Child's name _____
Child's DOB ___/___/___

Child's name _____
Child's DOB ___/___/___

Child's name _____
Child's DOB ___/___/___

ACCOUNT GUARANTOR

Person responsible for the account if other than patient _____

Billing Address _____
_____

DOB ___/___/___ *SSN* _____
Employer _____
Relationship to patient _____
Email _____
Home # (____) _____
Cell # (____) _____
Work # (____) _____

OUR PROMISE TO OUR PATIENTS

We personally promise to listen to your concerns and wishes. We promise we will use our gentle and painless approach to erase your fears and concerns about your dental care while we uncover your dazzling new smile. Our emphasis will always be on your comfort and satisfaction. We personally promise you will be thrilled with your procedure, or we will keep working until you are!

MEDICAL HISTORY

_____

_____

_____

_____

_____

_____

PLEASE RESPOND TO EACH QUESTION

Are you under medical treatment now? Y N
Are you taking any prescription, over-the-counter, or herbal supplement drugs? Please list each one:

_____

_____

Have you ever taken Fosamax, Actonel or any other bisphosphonate? Y N
Do you, or have you used tobacco? Y N
Do you use controlled substances? Y N
For women: Are you using a prescribed method of birth control? Y N Are you pregnant? Y N
Has a doctor told you that you need to take antibiotics before dental treatment? Y N
Are your teeth sensitive to hot or cold? Y N
Do you have pain in your jaw joints? Y N
Do you have significant dental problems? Y N
Have you ever had a negative experience with previous dental work? Y N
Are you happy with your smile? Y N
Would you like to have whiter teeth? Y N

PLEASE RESPOND TO EACH QUESTION

Are you allergic to any of the following?

Y N Penicillin	Y N Latex
Y N Clindamycin	Y N Tetracycline
Y N Erythromycin	Y N Any metals
Y N Epinephrine	Y N Other: _____
Y N Codeine	_____

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

Y N Stroke	Y N Heart attack/surgery
Y N Abnormal bleeding	Y N Glaucoma
Y N Artificial joints	Y N Rheumatic Fever
Y N Liver disease	Y N Cancer/chemotherapy
Y N Diabetes	Y N AIDS/HIV infection
Y N Kidney disease	Y N Hepatitis
Y N Seizures	Y N High/low blood pressure
Y N Thyroid problem	Y N Respiratory problems
Y N Cardiac pacemaker	Y N Asthma
Y N Radiation therapy	Y N Congenital heart defect

Please list all other medical conditions: _____

_____

I certify that the information I have given is complete and correct to the best of my knowledge.

Signed: _____ **Date** ___/___/___

FINANCIAL & CANCELLATION POLICY

We are committed to providing you with the best possible dental care! In order to achieve this, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment, give you a detailed treatment estimate, and answer any questions that we can about your insurance. As a courtesy to you, we will file claims with your dental insurance carrier on your behalf. Any portion not covered by insurance is your responsibility. Co-payment is due on the date of service unless other arrangements are made in advance.

We expect that our patients will honor the appointment times we reserve exclusively for them. We understand that your time is valuable and we appreciate the same respect in return. **All cancellations or missed appointments with less than 48 hours notice are subject to a $30.00 fee.**

I authorize my insurance company to directly pay Dr. Brink the insurance benefits otherwise payable to me. I also authorize him to release any information he deems necessary in connection with my treatment and/or the treatment of my children to my insurance company and/or other health practitioners.

Signed:_____ **Date:** ___/___/___

Our office is HIPAA (Health Insurance Portability and Accountability Act of 1996) compliant. To comply with one of HIPPA'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. By signing below, you acknowledge you have received a copy of the Notice of Privacy Practices.

Signed:_____ **Date:** ___/___/___