HEALTHY POINTE DENTAL, PC
18100 Mack Avenue
Grosse Pointe, MI 48230
www.healthypointedental.com

Today's Date: _____

Name _____ Preferred Name _____
Address _____ Email Address _____
City _____ State _____ Zip _____
Occupation _____ Employer _____ S.S.# _____
Telephone: Home (___) _____ Bus (___) _____ Cell (___) _____
Date of Birth _____ Age _____ Marital Status _____ Gender _____
In case of emergency, name, address and phone number of person not living with you who will know how to reach you: _____

_____

Referred by _____ Relationship _____

If you have dental insurance, please complete the insurance section below.

Subscriber's Name _____ Subscriber's Soc. Sec. No. _____
Subscriber's Place of Employment _____ Subscriber's D.O.B. ___/___/___
Patient's relationship to subscriber _____ Insurance Company Name _____

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Do you have secondary dental coverage? YES NO If yes, complete below.
Subscriber's Name _____ Subscriber's Soc. Sec. No. _____
Subscriber's Place of Employment _____ Subscriber's D.O.B. ___/___/___
Patient's relationship to subscriber _____ Insurance Company Name _____

Reason for today's visit: _____

YES NO Would you like to put a credit card on file to pay any outstanding balance on your account (after applicable dental insurance has been paid). A transaction receipt will be mailed or emailed to you.

For Parents of Children:

YES NO I authorize this office staff to do fluoride treatments or radiographs when warranted and a parent is unavailable to ask.

YES NO I authorize this office staff to perform routine dental teeth cleanings and exams if a parent is not present with the child (17 years and under) at their appointment.

Consent:

- I understand the above information is necessary to provide me with safe and efficient dental care. I have answered all questions truthfully and to the best of my knowledge.
- I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- This office believes dental radiographs are a necessary diagnostic tool and are required for a comprehensive evaluation of your dental health. Typically, full mouth radiographs are necessary every five years.
- I understand that all responsibility for payment for dental services provided in this office for me or my dependents is mine, payable at the time services are rendered unless other arrangements have been made.

Thank you for taking the time to read and fill out this questionnaire.

Patient Signature X _____ **Date:** _____

TURN OVER

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ASSIGNMENT FORM

Due to the many changes in dental insurance policies and health care, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE

Failing to comply with this instruction could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company and not with the insurance company and your dentist or this office.

- Even if treatment is pre-authorized with an insurance company, coverage may vary and I agree to pay for any discrepancy.
- Insurance is my benefit, I am responsible for full payment at the time of my visit.

Patient/Legal Guardian Name_____

Patient/Legal Guardian Signature:_____

Date:_____

Witness:_____

I authorize the release of any medical or dental information necessary to investigate or process any insurance claim.

Patient Initials:_____Date:_____