



COSMETIC & FAMILY DENTISTRY

Medical Square • 1579 West Big Beaver Road • Suite B6 • Troy, Michigan 48084 • (248) 649-2868 • www.ONielDental.com

- Dr.
- Mr.
- Mrs.
- Miss

PATIENT REGISTRATION

_____ Date _____
(First) (MI) (Last)

I prefer to be called _____ Date of Birth _____
(name)

Home Address _____ Home Tel. _____

City _____ Zip _____ Soc.Sec.No. _____

Cell Phone: _____ Email address: _____

Employer _____ Address _____

Occupation _____ Bus. Tel. _____

Primary Insurance: _____
(Please present insurance card)

Group Plan _____ Group Numbers _____

Secondary Insurance Program (if any) _____

Person Responsible for Account _____
(Self, Spouse, Parent, or Guardian)

Purpose of Call _____

Who may we thank for this referral? _____

It is important for you to be informed that our professional services are rendered and charged to YOU, not to the insurance company. Any procedures that involve co-payments must be paid for at the time of service. This assumes that you are eligible at that time and that we received the appropriate payment from your carrier. You are responsible for any and all charges not covered by your insurance carrier. I understand that if I cancel an appointment with less than 24 hours notice there may be a failed appointment fee, which I agree to pay before any further appointments can be scheduled.

Sincerely,
Philip D. O'Niel III, D.D.S

I understand and agree to the above. _____
Signature

Philip D. O'Neil III, D.D.S., P.C.

HEALTH QUESTIONNAIRE

Patient's name: _____ Date: _____

To enable us to make your care as comfortable and as safe as possible, please complete the following health questionnaire. INSTRUCTIONS: If your answer is YES to the question asked, put a check to the left of YES. If your answer is NO to the question asked, put a check to the left of NO. Answer all questions. Please add comments to answers which require explanation by writing in the space between questions. Thank you.

1. Are you in good general health? YES NO

2. Are you being treated for any condition by a physician now? For what: YES NO

3. Are you taking any medication now? List all meds: _____ YES NO

4. Have you been examined by your physician within the last year? YES NO
Date of your last physical examination? _____

5. Has there been any change in your general health in the last year? If yes, explain _____ YES NO

6. Have you ever been seriously ill? If yes, explain: _____ YES NO

7. Have you ever been hospitalized or had a major operation? _____ YES NO

8. Do you smoke? YES NO Frequency? _____

9. Have you ever experienced a bad reaction to any of the following drugs?

- | | | | |
|---------------------|--|--------------------|--|
| Aspirin | <input type="checkbox"/> YES <input type="checkbox"/> NO | Erythromycin | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Penicillin | <input type="checkbox"/> YES <input type="checkbox"/> NO | Barbiturates | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Iodine | <input type="checkbox"/> YES <input type="checkbox"/> NO | Codeine | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sulfonamides(Sulfa) | <input type="checkbox"/> YES <input type="checkbox"/> NO | Any other medicine | <input type="checkbox"/> YES <input type="checkbox"/> NO |

10. Have you had any of the following?

- | | | | |
|--------------|--|---------------------|--|
| AIDS | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Allergies | <input type="checkbox"/> YES <input type="checkbox"/> NO | High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO | HIV | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO | Rheumatic fever | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Glaucoma | <input type="checkbox"/> YES <input type="checkbox"/> NO | Stroke | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Attack | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Murmur | <input type="checkbox"/> YES <input type="checkbox"/> NO | Venereal Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |

11. Do you ever have convulsions? YES NO

12. Do you have a tendency to faint? YES NO

13. Have you ever had trouble with **prolonged** bleeding? YES NO
14. Have you ever had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or on your lips? For what? YES NO
15. Are you **dissatisfied** with the appearance of your teeth? YES NO
16. Have you ever had a bad reaction to a dental anesthetic? YES NO
17. Have you ever had any injury to your face or jaw? YES NO
18. Do you have any sensitive teeth? YES NO
19. Have you had a toothache recently? YES NO
20. Do you have bleeding gums? YES NO
21. Do you have frequent canker sores or cold sores? YES NO
22. Do you have frequent, severe headaches? YES NO
23. Does your jaw click when you chew? YES NO
24. Have you ever had any orthodontic treatment? YES NO
- 25. WOMEN** - are you pregnant at the present time? YES NO
26. Who was your previous Dentist? _____
 Date of last prophylaxis (cleaning): _____
 Date of last xrays: _____
 Frequency of brushing: _____
 Frequency of flossing: _____
27. Is there any other information that should be known about your health? YES NO
28. Is there any other information that should be known about your previous dental visits? YES NO

DATE: _____ Patient's Signature: _____

Philip D. O'Niel III, D.D.S., P.C.

PATIENT CONSENT TO TREATMENT

The following information is not presented to worry or alarm you but rather to conform to the principles of "INFORMED CONSENT":

I, the undersigned, understand that there can occasionally be complications associated with dental treatment. These complications can include: 1. unusual healing, infection, pain and swelling, 2. persistent numbness or other abnormal sensations in the lips, cheeks, tongue or other areas of the mouth and face, 3. sensitivity to biting, 4. failure of treatment causing the need to remove a tooth, 5. broken instruments that need to be left inside teeth, which can cause treatment to fail, 6. soreness in the area of the injections (shots), 7. soreness in or around the gums of the teeth worked on, 8. sensitivity to hot and/or cold foods, 9. abscessing of the teeth following treatment with fillings, crowns, or bridges, 10. irritation/laceration of the cheeks, lips, tongue and other tissues by dental appliances, dentures and dental equipment used during treatment, 11. breaking of teeth, 12. soreness in muscles or jaw joints, 13. rare reactions to injections (shots), such as allergic reactions, or inflammation of a vein and, 14. nausea or allergic reactions caused by medications.

Additionally, I understand there can be complications and risks associated with deciding to receive no treatment for dental diseases. These risks can include: 1. pain, 2. development and spread of infection, disease and injury to other areas of the mouth and body, and 3. loss of teeth.

By signing this form, I acknowledge: 1. I have read and understand the information in this form, 2. I understand my dentist is available to answer my questions, 3. I understand my dentist may appoint other persons to perform or assist in the performance of my dental treatment and procedures, 4. I am giving my permission to my dentist to use drugs and medications needed in my treatment and I understand, that in rare instances, unusual allergic or other reactions can occur to these drugs and medications, 5. I understand it cannot be predicted how long the beneficial results of my dental treatment will last, however, I do understand the more I follow the recommended maintenance program of brushing, flossing, exams, and cleanings, the longer the results will last, and 7. I understand that in dealing with the complex individual characteristics and unpredictability of the human body, it is occasionally impossible to diagnose and treat a problem and that occasionally, extremely unusual complication and outcomes, not known or mentioned in this form, can occur.

Signature of
PATIENT OR LEGAL GUARDIAN

DATE

Philip D. O'Niel III, D.D.S.

Philip D. O'Neil III, D.D.S., P.C.

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA'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.

PLEASE SIGN THIS FORM BELOW UNDER THE READING 'ACKNOWLEDGEMENT' TO ACKNOWLEDGE THAT YOU HAVE TODAY RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: 1. A defense to a claim challenging our professional competence; 2. A review entity's functions; 3. A claim for payment of fees; 4. A third party payer's examination of our records; 5. A court order as part of a criminal investigation; 6. An identification of a dead body; 7. A licensure investigation; or 8. A child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment or collecting our fees.

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING 'CONSENT' TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have today received a copy of the Notice of Privacy Practices

Patient Name (print) Patient Signature Date

PATIENT CONSENT

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment.

Patient Name (print) Patient Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Hipaa consent

Philip D. O'Niel III, D.D.S., P.C.

Personalized Smile Evaluation

Our goal is to provide the best possible treatment to meet your dental needs. We want to get to know you and your perception of your teeth and smile. We believe that by collecting this information, we can better serve you in the personalized manner that you and your family deserve. Please take a moment to fill out the following Personalized Smile Evaluation. Thank you!

Name: _____ Date: _____

On a scale of 1 to 10, how do you feel about your teeth and smile? Please comment:

1 2 3 4 5 6 7 8 9 10

Are your teeth crooked or crowded and is that a concern to you? Please comment:

Do you have any spaces between your teeth that concern you? Please comment:

Do you like the color of your teeth? Please comment:

Do you like the shape of your teeth? Please comment:

What would you like to change about the appearance of your smile?

Thank you for your time. We will use this information to explain the options available to improve your smile and your health.