Patient Number

HEALTH HISTORY & REGISTRATION

Patient's Name: Last_____ First _____ Middle Initial ___ Sex: M F Birthdate _____

If Patient is a Minor, give Parent's or Guardian's Name _____

Reason for visit _____ Today's Date _____

Who may we thank for referring you to our office _____

Residence: Street _____ City _____ State _____ Zip_____

Home Phone: _____ Cell: _____ Office: _____

Social Security Number _____-_____-_____ Drivers License _____ Marital Status _____

Employer_____ Occupation _____ No. Years Employed_____

SPOUSE'S INFORMATION

Spouse's Name _____

Employer _____ No. Years Employed _____

Occupation _____ S.S. No. _____-____-____

Work phone _____ Birthdate _____

EMERGENCY INFORMATION

(Relative not living with you)

Name _____

Address _____

City _____ State____ Phone _____

DENTAL INSURANCE INFORMATION

Primary Carrier

Insured's Name _____

Insurance Co. _____

Insurance Address _____

_____

Insured's Employer _____

Insured's Social Security No. _____-_____-_____

Group Number _____

Birthdate _____

Secondary Carrier

Insured's Name _____

Insurance Co. _____

Insurance Address _____

_____

Insured's Employer _____

Insured's Social Security No. _____-_____-_____

Group Number _____

Birthdate _____

DENTAL HISTORY

(Circle your response)

What is the reason for your visit? _____

When was your last set of full mouth x-rays taken? _____

How many times a year do you have your teeth cleaned? _____

Have you ever had complications following dental treatment? .... Yes No

If yes, please explain: _____

Are you concerned about receiving dental treatment? ..... Yes No

Have you ever had a severe injury to your face, teeth or jaw? .... Yes No

Have you ever had surgery in your mouth or on your lips? ..... Yes No

Are your teeth sensitive to hot, cold or pressure? ..... Yes No

Do your gums bleed when you brush? ..... Yes No

Do you have frequent or recurrent sores in your mouth? ..... Yes No

Have you ever had periodontal treatment for your gums? ..... Yes No

Have you ever had treatment to straighten your teeth? ..... Yes No

Have you had a recent toothache? ..... Yes No

Have you ever had extractions of any teeth? ..... Yes No

If yes, for what reason? _____

Do you clench or grind your teeth? ..... Yes No

Do you have any difficulty opening your mouth wide? ..... Yes No

Does your jaw click, pop or hurt when you chew? ..... Yes No

Are you satisfied with the appearance of your teeth? ..... Yes No

Do you have any further concerns or additional info? ..... Yes No

If yes, please specify: _____

Any prolonged bleeding following extractions? ..... Yes No

What is the name and address of your previous dentist?

_____

_____

PLEASE COMPLETE NEXT PAGE

MEDICAL HISTORY

(Circle your response)

1.	Have you ever had Rheumatic fever?	Yes	No
2.	Do you have hypertension (high blood pressure)?	Yes	No
3.	Heart attack, irregular heart rate or angina?	Yes	No
4.	Do you have mitral valve prolapse or damaged heart valves?	Yes	No
5.	Have you ever had a stroke?	Yes	No
6.	Do you have a heart murmur?	Yes	No
7.	Do you have chest pain or shortness of breath on exertion?	Yes	No
8.	Any blood disorders such as anemia or hemophilia?	Yes	No
9.	Frequent nose bleeds, increased bruising or bleeding?	Yes	No
10.	Asthma, tuberculosis or hay fever?	Yes	No
11.	Hives or a skin rash?	Yes	No
12.	Have you ever had a reaction to any drugs?	Yes	No
	If yes, what drugs? _____		
13.	Do you have allergies?	Yes	No
14.	Are you immunosuppressed (subject to frequent infections)?	Yes	No
15.	Have you been told that you have AIDS, ARC or are HIV positive?	Yes	No
16.	Do you have ulcers, stomach or intestinal problems?	Yes	No
17.	Hepatitis (jaundice) or liver disease?	Yes	No
18.	Diabetes (high blood sugar)?	Yes	No
19.	Frequent urination (six times / day), kidney disease or dialysis?	Yes	No
20.	Increase in thirst?	Yes	No
21.	Tendency to faint, have convulsions, seizures or epilepsy?	Yes	No
22.	Do you now or have you ever used tobacco products?	Yes	No
23.	Do you consume alcoholic beverages?	Yes	No
	If so, how many drinks per week _____		
24.	Are you taking ANY medications now?	Yes	No
	If yes, please list prescription and non-prescription drugs: _____		
	_____		
25.	Do you get frequent or severe headaches?	Yes	No
26.	Have you ever had eye, ear, nose or sinus problems?	Yes	No
27.	Are you in good health?	Yes	No
28.	Do you feel you're under excessive stress?	Yes	No
29.	Arthritis (painful, swollen joints)?	Yes	No
30.	Have you ever had an artificial joint placed?	Yes	No
31.	Have you had cancer, chemotherapy or radiation therapy?	Yes	No
32.	Veneral disease (syphillis, gonorrhea, herpes or other)?	Yes	No
33.	Have you ever had a blood transfusion?	Yes	No
34.	Are you being treated by a physician now?	Yes	No
	If yes, for what condition? _____		
35.	Been hospitalized, had major surgery, been seriously ill or hurt?	Yes	No
36.	Any further questions, concerns or additional information?	Yes	No
	If yes, please specify: _____		
37.	Women: are you pregnant?	Yes	No
38.	Physician's name: _____		
	Address: _____		

CONSENT

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor, and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payment received by the Doctor from the insurance coverage will be credited to my account, or refunded to me if I have paid the dental fee incurred.

PATIENT Signature (parent of child): _____ Date: _____

DENTIST Signature: _____

Mark D. Zahn, D.D.S., M.S., P.C.
2207 Jackson Avenue
Ann Arbor, Michigan 48103
(734) 994-9145

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Printed Name: _____

Signature: _____

Today's Date: _____

I hereby authorize the following person to be privy to my personal information (e.g.; medications, appointment reminders, etc.) during correspondence, if needed.

Printed Name of Additional Person: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained for the following reason:

□ Individual refused to sign

□ Communications barrier

□ An emergency situation

□ Other: _____

Mark D. Zahn D.D.S., M.S., P.C.
2207 Jackson Avenue
Ann Arbor, Michigan 48103

Patient's Name (please print): _____

Patient's Date of Birth: _____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I can withdraw my consent to electronic communications by calling the office phone number: **734-994-9145**

I am responsible for providing the dental practice any updates to my email address.

*****PLEASE PRINT CLEARLY*****

Email Address: _____

Patient's Signature: _____

Today's Date: _____

Mark D. Zahn, D.D.S., M.S., P.C.
2207 Jackson Avenue
Ann Arbor, Michigan 48103
(734) 994-9145

Cancelation Policy

This office has instituted a policy of charging a fee for missing an appointment, or canceling with less than two (2) business days' notice. This policy is explained by this notice at your first visit, and confirmed by your signature below. We reserve the right to charge for missed appointments, with the understanding that the rates will vary on the appointment type and length. Please contact the front office staff for the current rates.

The purpose of this policy is to encourage patients to take their appointments as seriously as we do. Your appointment time is reserved for you, and you alone. If you do not keep your scheduled appointment time other patients who need urgent treatment are forced to wait longer than necessary.

We do understand that acute health concerns, and family crisis are unavoidable, but cancelations of inconvenience will be your responsibility. We are available to discuss this policy in general, or pertaining to individual circumstances. Thank you for your understanding in this matter.

_____ _____

Signature Date

Benefits

Your benefit coverage is a contract between you and your insurance company. We will submit your claim to your insurance company for payment of any covered benefits.

We will do our best to provide you with an estimate of your insurance benefits. Please remember that insurance estimates are subject to yearly maximums, fee schedules, exclusions, copays, and deductibles. We are unable to monitor what other offices have billed, and what the insurance company has paid to other providers. Remember that fees quoted are only an estimate, and not a guarantee of payment. Estimated copayments are due at the time of service.

If you do not have dental benefits, you are responsible for payment at the time services are rendered.

_____ _____

Signature Date