Paul S. Busch, D.D.S., P.C.
Gentle Dentistry
530 Nichols Road
Kalamazoo, MI 49006
(269) 381-3890

Patient Information Form

Name:
First_______________________Last______________________________Middle___________________

Social Security Number__________________________________Date of Birth___________________________

Home Address:
Street________________________________City______________________Zip_________________

Contact Information: (please indicate best time/method of reaching you)
Home Phone____________________________Cell Phone______________________________________

Email address____________________________Work Phone_________________________ext.________

Employment:
Name______________________________________Human Resource Number________________________

Street______________________________City___________________________Zip_______________

Nearest Relative/Friend NOT living with you____

Relationship to you______________________________Home Phone_________________________________

Whom may we thank for referring you to us? Please check all of the options below that apply.

Friend ________________Family member ______________________T.V. ad _____Website_______

Yellow Book ______Yellow Pages ______Blue Card ________Other____________________

Who is Financially responsible for treatment?____

I will be paying today by: Cash_______________Check_______________Credit Card____________________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

____ ____________________________
Patient Signature Date

Primary Dental Insurance Form

Subscriber name and address______________________________________

____

Relation to insured:______________ SS#_________________ DOB_____________

Employer name and address:____

____

Insurance Company Name and Address___________________________________

____

Group Number__________ Fam. Yearly Ded.___________ Ind. Yearly Ded.________

Secondary Dental Insurance Coverage

Subscriber name and address______________________________________

____

Relation to the insured:______________ SS#_______________DOB_____________

Employer name and address____

____

Insurance Company Name and Address:__________________________________

____

Group Number___________ Fam. Yearly Ded.________ Ind. Yearly Ded.__________

Responsible party for patient:______________________________________

Name and Address:____

Signature:____

Any additional information please write on a separate sheet of paper- thank you! ☺

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Dental History	Name of previous dentist ______________
	Date of last dental visit? ☐ 0-6 months ☐ 6-12 months ☐ 12-24 months ☐ greater than 24 months
	Date of last x-rays? ☐ 0-6 months ☐ 6-12 months ☐ 12-24 months ☐ greater than 24 months
	How often do you floss? ______________
	How often do you brush? ______________

☐	Tooth pain	☐	Broken fillings	☐	Sensitivity to sweets
☐	Bleeding gums	☐	Orthodontic treatment	☐	Sensitivity when biting
☐	Finger or nail biting	☐	Periodontal treatment	☐	Frequent headaches
☐	Bad breath	☐	Pain in jaw joints	☐	Fear of dentist
☐	Grinding teeth	☐	Sensitivity to cold	☐	Swelling or lumps in mouth
☐	Loose teeth	☐	Sensitivity to heat	☐	Missing teeth
☐	Complications with extractions	☐	Removable partial or denture	☐	Food wedged between teeth

Health History

Health History	Name of previous Physician ______________
	Date of last physical exam? ☐ 0-6 months ☐ 6-12 months ☐ 12-24 months ☐ greater than 24 months
	Do you smoke or use tobacco? ☐ Yes ☐ No
	If Female please answer
	Are you taking Birth Control Pills? ? ☐ Yes ☐ No
	Are you pregnant? ☐ Yes ☐ No If Yes, # of weeks ______________
	Are you nursing? ☐ Yes ☐ No

Allergies to medications

☐	Aspirin	☐	Erythromycin	☐	Metals
☐	Codeine	☐	Jewelry	☐	Penicillin
☐	Dental Anesthetics	☐	Latex	☐	Tetracycline

☐	Other: ____

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐	Abnormal Bleeding	☐	Diabetes	☐	High Blood Pressure
☐	Acid reflux	☐	Difficulty Breathing	☐	HIV+ AIDS
☐	Alcohol Abuse	☐	Drug Abuse	☐	Liver Disease
☐	Allergies	☐	Emphysema	☐	Low Blood Pressure
☐	Anemia	☐	Epilepsy	☐	Mitral Valve Prolapse
☐	Angina Pectoris	☐	Fainting Spells	☐	Pace Maker
☐	Arthritis	☐	Fever Blisters	☐	Psychiatric Problems
☐	Artificial Bones	☐	Frequent	☐	Radiation Therapy Kidney Problems
☐	Artificial Heart Valve	☐	Glaucoma	☐	Rheumatic Fever
☐	Artificial Joints	☐	Hay Fever	☐	Sinus Problems
☐	Asthma	☐	Headaches	☐	Stroke
☐	Blood Transfusion	☐	Heart Attack	☐	Thyroid Problems
☐	Cancer-Chemotherapy	☐	Heart Surgery	☐	Tuberculosis
☐	Colitis	☐	Hemophilia	☐	Ulcers
☐	Congenital Heart Defect	☐	Hepatitis A	☐	Yellow Jaundice
☐	Cosmetic Surgery	☐	Hepatitis B	☐	Other:____________________

Please list all medications you are taking

Name the Drug	Strength	Frequency Taken

Signature______________________________ Date_______________

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or heath care operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________

Relationship to Patient: ______________________

Signature: ______________________

Date: ______________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

Dr. Paul S. Busch, D.D.S., P.C.

We welcome you as a patient and appreciate the opportunity to provide you with the best care that is available.

Thank you for choosing us as your dental care provider. Our purpose is to enable our patients to achieve excellence in dental health and freedom from head and neck pain. We will make every effort to provide gentle dentistry in a caring and pleasant atmosphere.

Our Office Policy

We require each patient to read and sign our office policy prior to any treatment. All patients must complete our "Patient Information Forms" before being seen by the doctor.

Appointments:

Unless notified at least 24 hours in advance, our policy is to charge for missed appointments. Cancellations left on the answering machine must also be 24 hours in advance. This courtesy allows us to give the appointment times to patients who are waiting.

Payment Methods:

Full payment is expected at the time of service. We accept cash, check, Visa and Master card; we also accept debit/check cards and Care Credit. Care Credit plans require prior approval, and offer no interest plans depending on amount financed.

Minor Patients:

Minor patients must be accompanied by their parent or guardian. Unaccompanied minors may be denied treatment unless prior arrangements have been made.

Insurance:

We may accept assignment of insurance benefits providing all paperwork and necessary information is complete. However, we do require that deductibles and co-payments be paid at the time of service. Your insurance policy is a contract between you, your employer, and the insurance company. If any services are rejected, you are responsible for any fees that your insurance company includes. We allow 45 days grace period for all insurance claim payments to arrive. If no payments have been made by then, the balance may be transferred to you. All balances are due upon receipt and are subject to a monthly billing charge if more than 30 days overdue.

I have read the office policy, understand and agree with it.

Signature Date

Thanks, Paul S. Busch, D.D.S.