FAMILY, COSMETIC & IMPLANT DENTISTRY

Patient _____ Date: _____
Last First Initial

Medical Health: (Please circle one) Excellent Good Fair Poor

Physician's Name: _____

Last Completed Physical: _____ Are you under a doctor's care now? Yes No

If yes, for what reason? _____

Please list any medications, pills or drugs you are taking: _____
_____

Are you pregnant? Yes No If yes, how far along? _____ Due Date:_____

Are you subject to prolonged bleeding? Yes No If yes, last occurrence? _____

Are you allergic to Penicillin Codeine Local Anesthetics Aspirin
Other:_____

Do you use tobacco products? Yes No How long have you used them?_____
Tobacco type:_____ Would you like to quit? Yes No

Please CIRCLE if you have or have had any of the following:

Heart Trouble/Condition	Anemia	Stroke	Cancer
Heart Murmur	Chest Pain	Diabetes	Chemotherapy/Radiation
Congenital Heart Lesion	Shortness of Breath	Kidney Trouble	Glaucoma
Artificial Heart Valve	Fainting or Dizziness	Emphysema	Prostate Issues
Heart Pacemaker	Swelling of Feet/Ankles/Hands	Lung Disease	Psychiatric Care
Heart Surgery	Arthritis/Gout	Liver Disease	Recent Weight Loss
Mitral Valve Prolapse	Allergies	Thyroid Disease	Hepatitis A (infectious)
Pre-Medication	Hay Fever	Parathyroid Disease	Hepatitis B (serum)
Artificial Joints/Hip/Knee	Asthma	Epilepsy or Seizures	HIV/Positive/Aids
High Blood Pressure	Sinus Trouble	Alzheimer's Disease	Hypoglycemia
Low Blood Pressure	Frequent Cough	Autistic/Special Needs	Hemophilia
Blood Disease	Ulcers/Stomach Problems	X-ray/Cobalt Treatment	Rheumatic Fever

Have you ever had any other serious illness not circled above? Yes No Please Describe:_____
_____
_____

Is there any other information that we should know?
_____
_____

Dr. Thomas J. Burdo, DDS
1100 4 Mile NW
Grand Rapids, MI 49544
Phone (616) 784 -6377 or Fax (616) 784 -8472

FAMILY, COSMETIC & IMPLANT DENTISTRY

Confidential Patient Information

Patient_____/_____
Last First Initial Preferred Name

Address:_____
Street City State Zip

Phone (Home):_____(Work):_____(Other)_____

Drivers License #_____ E-Mail Address:_____

Date of Birth _____ SS#_____ Male Female

Height: _____ft. _____in. Weight: _____# Marital Status: Single Married Divorced Widowed

Hobbies: _____

Place of Employment: _____Phone #:_____Occupation: _____

Business Address:_____
Street City State Zip

Person Responsible for Account:_____ Relationship to Patient_____

Spouse's Name _____

Emergency Contact Person_____ Phone #_____Relationship_____

Whom may we thank for referring you to our office? _____

Has any member of your family been treated in our office previously? Y or No Relationship _____

DENTAL HEALTH (Please circle one) Excellent Good Fair Poor

What priority do you give your teeth (10 being highest)? 1 2 3 4 5 6 7 8 9 10

Please circle A, B or C:

1. A) I think the appearance of my teeth is excellent.
   B) I am satisfied with the appearance of my teeth.
   C) I am dissatisfied with the appearance of my teeth.
2. A) I have set goals for my oral heath with a previous dentist.
   B) I want to set goals concerning my oral health.
   C) I have never set goals concerning my oral health.
3. What is most important to you in a dentist? _____
4. What is most important to you with your teeth? _____
5. If we could assist you in improving one goal concerning your dental health, what would it be?

_____

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Consent and Agreement

(*Please read the following information so you will understand the care and service we will provide.)*

1. It is the desire of this practice to treat each patient with the most current and best treatment options available. We can only be assured treatment can be completed with the patient's consent and understanding of the treatment plan, options and costs involved. If you need further clarification for any reason, please ask us.
2. Fees will be accessed for diagnostic, treatment, consultation or other dental services.
3. Payment is due when service is provided. Any payment agreements should be made before treatment is scheduled or completed. Cash, Check, Visa, MasterCard, Discover, Amex.
4. If payment is not completed within 90 days from date of service, a 30% collection fee will be added to the outstanding balance.
5. Please remember we have reserved time just for you and your dental health. If you must miss an appointment please be sure to give us 48 hours notice when possible.
6. Patient records and diagnostic information such as radiographs must remain as part of your permanent dental record of the practice.
7. Please ask questions at anytime. We would like you to always feel comfortable and completely informed of any services we recommend.

I will allow Dr. Thomas J. Burdo, DDS to perform those procedures and treatments including local anesthesia, which are deemed necessary. I know there are some risks inherent in all dental procedures including the administration of local anesthesia and administration of other drugs common to dental practice. I am aware that the risks involved are the same as those procedures performed in any private dental office, (i.e., possible allergic reactions to drugs, possible cuts or abrasions). I give permission to discuss my condition with my physician and to request medical information from my physician. Further, I certify that I understand and agree to the conditions set forth above.

PATIENT'S Signature: _____ **Date**:_____

IMPORTANT INSURANCE INFORMATION

Our doctors and staff desire to assist our patients in their collection of insurance assistance fir dental services. In order to avoid misunderstandings, please read the following statements carefully.

1. The insurance company has an obligation to the patient and *not* to the doctors.
2. The patient alone is obligated to the doctors for payment of services.
3. The doctors cannot state or guarantee what services the insurance company will assist with or the amounts of assistance. The patient must determine this from their insurance policy either by calling their insurance company or discussing this with their agent.
4. As a courtesy to the patient, the office will complete insurance forms and attempt to *estimate* insurance. This in no way relieves the patient of their obligation to the doctors nor does it imply that the fee for services is thereby settled.

Dental Insurance Company _____ Group # _____
Subscriber's Name_____ Relationship to Patient _____
Subscriber's Date of Birth _____/_____/_____ Subscriber's Soc. Sec. # _____/_____/_____
Employer _____

If your spouse has dental insurance, are you covered under that policy? Yes or No
Dental Insurance Company _____ Group # _____
Subscriber's Name_____ Relationship to Patient _____
Subscriber's Date of Birth _____/_____/_____ Subscriber's Soc. Sec. # _____/_____/_____
Employer _____

I HEARBY AUTHORIZE PAYMENT TO DR. THOMAS J. BURDO, DDS FOR THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

(THIS MUST BE SIGNED FOR PATIENTS COVERED BY INSURANCE.)

_____ _____
Subscriber's Signature Date

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Smile Analysis

Check all that apply:

- □ **I don't like the color of my teeth**
- □ **My teeth look worn down**
- □ **My teeth are chipped or cracked**
- □ **My teeth are crowded and not straight**
- □ **I feel like I have a "gummy" smile**
- □ **My teeth look too short**
- □ **My teeth look too long**
- □ **I have dark or silver fillings that I'd like replaced**
- □ **I have crowns with dark lines at the gum line**
- □ **I have a dark tooth/teeth from an injury**
- □ **I have tried over-the-counter whitening gel**
- □ **I like the results of my whitened teeth**
- □ **I use whitening toothpaste and/or mouthwash**
- □ **I am a smoker**
- □ **I drink ____ cups of coffee per day**
- □ **I drink ____ cups of tea per day**

Please list any other questions or concerns you have that would assist us in understanding the goals you have for your teeth and your smile:

_____
_____
_____
_____
_____

Name:_____ Date:_____

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Patient Acknowledgement and Consent Form

You have the right to read our Notice of Privacy Practices before you sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing the Consent.

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

X_____ _____
Patient Signature Patient Name (please print)

_____
Date

I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

X_____ _____
Patient Signature Patient Name (please print)

_____
Date

==========

Revocation of Consent (only complete if you are revoking the above signature)

I revoke Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked by Consent.

X_____ _____
Patient Signature Patient Name (please print)

FOR OFFICE USE ONLY:

Patient refused to sign because:
_____
_____
_____

Office personnel:_____ _____
(Print Name) (Signature)
Date:_____

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