Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

Keith W. Kelley, DDS • 1913 W. South Blvd. • Troy, Michigan 48098 • (248) 828-3185

PATIENT INFORMATION

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: _____
First MI Last

Address _____ Driver's Lic #_____ [ ] Male [ ] Female

City _____ State _____ Zip _____ Hm# (___)_____

Employer _____ Wk# (___)_____Ext _____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell # (____)_____

DOB: ____/____/_____SSN# _____ E-mail _____@_____

Spouse's Name _____
First MI Last (if different)

Spouse occupation _____ Work phone _____Ext _____

Is patient a full time student? [ ] No [ ] Yes: Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Hm# (___)_____

Wk# (___)_____

DOB: ____/____/_____

SSN# _____

Relationship: _____

YOUR PREFERENCES

Do you prefer appointment reminders by:
[ ] Email [ ] Phone [ ] Text

Do you prefer to receive calls from our office at:
[ ] Home [ ] Work [ ] Cell

How did you hear about our office?

_____

How do you wish to be addressed by our team members?

_____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____

DOB: _____/_____/_____ Subscriber's ID# _____

Insurance Company _____ Policy # _____ Group #_____

SUPPLEMENTAL INSURANCE (DENTAL):

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____ ID# _____ Employer: _____

Insurance Company _____ Group # _____

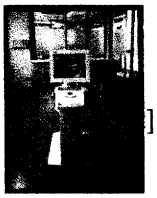
DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____ ID# _____ Employer: _____

Insurance Company _____ Group # _____



Our practice is one of the more technologically advanced practices in the US. We use 3-D CEREC technology to produce ceramic restorations in a single visit.

CONFIDENTIAL

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes _____
Primary Physician's Name and Phone # should we need to contact them	Physician's Name _____	Phone # _____
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes _____
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes _____
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes _____
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	If yes _____
Do you use controlled substances?	◯ Yes ◯ No	If yes _____
Do you take or need antibiotics before dental procedures?	◯ Yes ◯ No	If yes _____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No	Codeine	◯ Yes ◯ No	Acrylic	◯ Yes ◯ No
Metal	◯ Yes ◯ No	Sulfa Drugs	◯ Yes ◯ No	Local Anesthetics	◯ Yes ◯ No	Latex	◯ Yes ◯ No

Any other allergies? ◯ Yes ◯ No If yes _____

Do you have or have ever had:

Cancer	◯ Yes ◯ No	Fatigued/Tired	◯ Yes ◯ No	General Weakness	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
HIV/AIDS	◯ Yes ◯ No	Joint Replacement	◯ Yes ◯ No	Liver Problems	◯ Yes ◯ No	Recent Trauma/Injury	◯ Yes ◯ No
Rheumatic/Scarlet Fever	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Tumors or Growths	◯ Yes ◯ No						

Cardiovascular System

Artificial Heart Valve	◯ Yes ◯ No	Chest Pain or Angina	◯ Yes ◯ No	Heart Attack	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No
Tachycardia	◯ Yes ◯ No	Congenital Heart Defect	◯ Yes ◯ No	Congestive Heart Failure	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No

Endocrine

Diabetes	◯ Yes ◯ No	Thyroid Problems	◯ Yes ◯ No	Hormonal Change	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No

Eyes, Ears, Nose, Throat

Change in Hearing	◯ Yes ◯ No	Change in Vision	◯ Yes ◯ No	Difficulty Swallowing	◯ Yes ◯ No	Ear Pain	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Nasal Obstruction	◯ Yes ◯ No	Nose Bleeding	◯ Yes ◯ No
Sinus Problems	◯ Yes ◯ No	Tonsillectomy	◯ Yes ◯ No	Ringing in Ears (Tinnitis)	◯ Yes ◯ No		

Gastrointestinal

Acid Reflux	◯ Yes ◯ No	GERD	◯ Yes ◯ No	Soft of Special Diet	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No		

Comments

Dr.'s Review (initials)

Genitourinary

Frequent Urination	Yes No	Kidney Problems	Yes No	Nocturia (Bed)	Yes No	Genital Herpes	Yes No
Renal Dialysis	Yes No	Venereal Disease	Yes No				

Hematological

Bleeding Problems	Yes No	Hepatitis	Yes No	Blood Disease	Yes No	Hemophilia	Yes No
Anemia	Yes No	Leukemia	Yes No	Blood Transfusion	Yes No	Bruise Easily	Yes No

Musculoskeletal

Back Pain	Yes No	Fibromyalgia	Yes No	Arthritis/Gout	Yes No	Rheumatism	Yes No
Osteoporosis	Yes No	Spina Bifida	Yes No	Muscle Weakness	Yes No		

Neurological

Alzheimer's Disease	Yes No	Dizziness/Fainting	Yes No	Memory Loss	Yes No	Multiple Sclerosis	Yes No
Tremor	Yes No	Parkinson's Disease	Yes No	Convulsions	Yes No		

Oral

Bleeding Gums	Yes No	Dry Mouth	Yes No	Jaw Joint Problems	Yes No	Jaw Joint Clicking	Yes No
Jaw Joint Pain	Yes No	Difficulty Chewing	Yes No	Orthodontics/Invisalign	Yes No	Periodontal Disease	Yes No
Teeth clenching/grinding	Yes No	Tooth Pain	Yes No	Wisdom Teeth Extraction	Yes No	Have Removable Teeth	Yes No
Canker Sores	Yes No	Cold Sores/Fever Blisters	Yes No				

Psychiatric

ADD/ADHD	Yes No	Anxiety	Yes No	Chemical Dependency	Yes No	Depression	Yes No
Eating Disorders	Yes No	Excessive Stress	Yes No	Memory Problems	Yes No	Psychiatric Care	Yes No

Respiratory

Asthma	Yes No	Bronchitis	Yes No	Breathing Problems	Yes No	Congestion	Yes No
Emphysema	Yes No	Easily Winded/Dyspnea	Yes No	Pneumonia	Yes No	Frequent Cough	Yes No
Lung Disease	Yes No	Tuberculosis	Yes No				

Sleep

Daytime Sleepiness	Yes No	Morning Headaches	Yes No	Obstructive Sleep Apnea	Yes No	Do you use a CPAP	Yes No
Snoring	Yes No						

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

Dr.'s Review (initials)

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Keith W. Kelley DDS to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make athorough diagnosis of the undersigned patient's dental condition and needs. I authorize Keith W. Kelley, DDS to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Keith W. Kelley, DDS choose and employ such assistance as deemed necessary. I understand that the use of anesthetic agents embodies certain risks and consent to their use as deemed appropriate by Keith W. Kelley, DDS. To the best of my knowledge, the questions on this form have been accurately answered. I understant that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. This office will not bill a non-costodial parent. I understand that I am responsibile for any portion of fees for service rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 7% annual finance charge that will be applied to any balance over 30 days; returned checks will incur a $25.00 fee. I acknowledge that I am responsibile for all fees necessary to collect my account. I authorize Keith W. Kelley, DDS and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to him, and to handle any necessary claim appeal(s) on my behalf.

Signature of Patient, Parent or Guardian:

X Date:_____

Notice of Privacy Practices (below)

NOTICE OF PRIVACY PRACTICES: Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practice's policies and your rights regarding PHI.
I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

Patient Signature_____ Date:_____

Keith W. Kelley D.D.S.

1913 W. South Blvd, Troy, MI 48098
(248)828-3185

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME _____

ADDRESS:_____

TELEPHONE:_____ E-MAIL: _____

SOCIAL SECURITY # _____

PATIENT ID# _____

SECTION B: TO THE PATIENBT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the use 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 carefully and completely before signing this Consent.

We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: DeAnna LaMothe
Telephone: 248-828-3185 Fax: 248-828-0197
Address: 1913 W. South Blvd., Troy, MI 48098
Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand the revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature
I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. 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 our treatment, payment activities and healthcare operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative of behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my 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 in reliance 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 my Consent.

Signature:_____ Date: _____