PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

PLEASE PRINT PATIENT'S INFORMATION BELOW

NAME _____ PREFERS TO BE CALLED_____
First MI Last

ADDRESS _____ HOME PHONE _____
Street City State Zip

CELL PHONE _____ EMAIL_____

HOW DO YOU PREFER TO RECEIVE APPOINTMENT REMINDERS? (Please circle all that apply) PHONE EMAIL TEXT

BIRTHDATE_____ AGE_____ SOCIAL SECURITY NO. _____ - _____ - _____

GENDER: MALE FEMALE MARITAL STATUS (Please choose one): MARRIED SINGLE DIVORCED WIDOWED

OCCUPATION_____ EMPLOYER'S NAME _____ WORK PHONE _____

WORK ADDRESS _____ OK TO CALL WORK? YES NO
Street City State Zip

HOW DID YOU HEAR ABOUT OUR OFFICE? (Please circle all that apply)

WKZO WVFM – 106.5 GOOGLE SEARCH – WHAT DID YOU SEARCH FOR? _____

FACEBOOK WOMEN'S LIFESTYLE SPARK PORTAGE LIVING GULL LAKE LIVING HEART OF TEXAS CORNERS

SPECIFIC EVENT_____

PERSONAL REFERRAL _____ OTHER _____

Ask us about our referral program!

GETTING TO KNOW YOU

DO YOU HAVE A FAMILY MEMBER WHO IS A PATIENT AT OUR OFFICE? (Please circle one) YES NO

NAME _____RELATIONSHIP_____

PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME_____ RELATIONSHIP_____ PHONE_____

DENTAL INSURANCE

INSURANCE COVERAGE? YES NO SECONDARY COVERAGE? YES NO

PRIMARY INSURANCE COMPANY INFORMATION

NAME_____

PHONE #_____

SUBSCRIBER/MEMBER ID #_____

GROUP #_____

SECONDARY INSURANCE COMPANY INFORMATION

NAME_____

PHONE #_____

SUBSCRIBER/MEMBER ID #_____

GROUP #_____

SUBSCRIBER'S INFORMATION

SUBSCRIBER'S NAME_____

EMPLOYER'S NAME_____

SUBSCRIBER'S DATE OF BIRTH_____

SUBSCRIBER'S SOCIAL SECURITY #_____

SUBSCRIBER'S NAME_____

EMPLOYER'S NAME_____

SUBSCRIBER'S DATE OF BIRTH_____

SUBSCRIBER'S SOCIAL SECURITY #_____

PATIENT'S RELATIONSHIP TO SUBSCRIBER

SELF SPOUSE DEPENDENT

PATIENT'S RELATIONSHIP TO SUBSCRIBER

SELF SPOUSE DEPENDENT

Your Smile is Our Passion™

Susan M. Dennis, DDS 8150 Moorsbridge Rd. Suite A Portage, MI 49024 269.327.3400

CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I consent to the making of videotapes, photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

5. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations.

6. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made, in accordance with its credit terms and policy. If required, I also understand a check of my credit history may be made.

7. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Patient's Signature _____Date _____
Parent / Responsible Party's Signature _____
Relationship to Patient _____

Dr. Dennis Pre-Clinical Interview for Children

1. Do you have any initial concerns for your child? _____
2. Is your child having any problems with decay or gum disease? _____
3. Does you child drink juice, pop or sports drinks? _____
4. What kinds of treatments has you child undergone? _____
5. Has your child had regular dental care or sporadic dental care? _____
6. What does you child like most about coming to the dentist? _____
7. What does you child like least about coming to the dentist? _____
8. Are any teeth sensitive, causing pains, or bothering your child? _____
9. Does your child have problems with food wedging between back teeth when chewing? Y N
10. Do you and your child like the appearance of their teeth and smile? Parent Y N Child Y N
11. What would you or your child change about their mouth if you could wave a magic wand and do whatever they wanted with it? _____
12. Does your child chew on both sides of their mouth? Y N Unknown
13. Does your child clench or grind their teeth? Y N Unknown
14. Does your child have head aches? Y N Unknown
15. Does your child chew gum? Y N Unknown
16. Does your child have pain, clicking, or popping when they open or close or chew? Y N Unknown
17. How often does your child brush daily? _____ Vigorously or lightly
18. Are your child's gums sensitive or do their gums bleed? Y N Unknown
19. Is your child experiencing bad breath or a bad taste in their mouth? Y N Unknown
20. Has your child been taught how to floss? Y N Do they floss themselves? Y N
21. Is it difficult for you child to brush, floss or clean any area of their mouth? Y N Unknown
22. Does your child use mouthwash? Y N
23. How often do you have your child's teeth cleaned? _____ times a year
24. Do your child's gums bleed when they have their teeth cleaned? Y N Unknown Is it painful? Y N

Myofunctional Therapy

25. Is your child a sloppy eater? Y N
26. Does your child suck their thumb, finger or pacifier? Y N
27. Is your child a mouth breather? Y N
28. When your child gets tired, do they slur their words? Y N

Signature: _____ Date: _____

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

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

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	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	
Do you require antibiotics prior to dental visits due to heart or joint replacement surgery?	Yes No	
Have you had the HPV vaccination?	Yes No	

Women: Are you...

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

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

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

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

SUSAN M. DENNIS, D.D.S.

VELscope Screening Consent

What every person needs to know about oral cancer.
And what we're doing to protect you from it.

Our team continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and carefully examine every patient for oral pathology.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased risk*: patients age 18-39*
High risk*: patients age 40 and older; tobacco users (any age, any type within 10 years)*
Highest risk*: patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer*

We have recently incorporated VELscope into our oral screening standard of care. We find that using VELscope along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. VELscope is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The VELscope exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is $36.

☐ **Yes.** I authorize the clinician to perform the VELscope exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name:_____

Signature:_____ Date:_____

☐ **No**. I would prefer not to have the VELscope exam at this time.

Print name:_____

Signature:_____ Date:_____