CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME:	LAST	FIRST	MIDDLE	DATE OF BIRTH: / /	SEX: ☐M ☐F	SOCIAL SECURITY:
PATIENT'S ADDRESS:	STREET	APT#	CITY	STATE	ZIP	HOME PHONE:
MARITAL STATUS: ☐M ☐S ☐D ☐W ☐ UNDER AGE 18	PATIENT'S/ GUARDIAN'S EMPLOYER:		OCCUPATION:	EMAIL:		
WORK ADDRESS:	STREET	CITY	STATE	ZIP	CELL PHONE:	WORK PHONE:	OKAY TO CALL WORK: ☐ YES ☐ NO
SPOUSE'S NAME:	LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER:	OCCUPATION:	
WORK ADDRESS:	STREET	CITY	STATE	ZIP	CELL PHONE:	WORK PHONE:	OKAY TO CALL WORK: ☐ YES ☐ NO

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME):

NAME: RELATIONSHIP: PHONE(S)#:

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE:	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE:

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE: ☐ YES ☐ NO	INSURANCE COMPANY NAME:	ADDRESS	INSURANCE PHONE #:
SUBSCRIBER'S NAME:	PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH: / /	SUBSCRIBER'S SOCIAL SECURITY #:
GROUP/PROGRAM NUMBER:	EMPLOYER (IF DIFFERENT FROM ABOVE):	EMPLOYER ADDRESS:	

SECONDARY COVERAGE: ☐ YES ☐ NO	INSURANCE COMPANY NAME:	ADDRESS	PHONE
SUBSCRIBER'S NAME:	PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH:	SUBSCRIBER'S SOCIAL SECURITY #:
GROUP/PROGRAM NUMBER:	EMPLOYER (IF DIFFERENT FROM ABOVE):	EMPLOYEE ADDRESS:	

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorized that my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay aid office in accordance with its credit terms and policy.

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.

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

Signature______________________________ **Date** __________

44725 Grand River Ave Suite 200, Novi, MI 48034

Patient Medical History

Patient name: ______________________________ Date: __________

1. Are you under medical treatment now? □ yes □ no
2. Have you ever been hospitalized for any surgical operation or serious illness with the last 5 years?
   If yes, please explain______________________
3. Are you taking any medication(s) including non prescription medicine? □ yes □ no
   If yes, what medication(s) are you taking?
   ____
   ____
   ____
4. Do you use tobacco? What type?________ How much? ________ □ yes □ no
5. Are you considered a touchy person? □ yes □ no
6. Are you often unhappy or depressed? □ yes □ no
7. Are you easily upset or irritated? □ yes □ no
8. Do you use controlled substances? □ yes □ no
9. Do you have trouble wearing contact lenses? □ yes □ no
10. **Do you have or have you had any of the following?**

High/ low blood pressure	□ yes □ no	Leukemia	□ yes □ no
Rheumatic fever	□ yes □ no	Swollen ankles	□ yes □ no
Fainting/seizures	□ yes □ no	Asthma	□ yes □ no
Diabetes	□ yes □ no	Kidney diseases	□ yes □ no
AIDS or HIV infection	□ yes □ no	Thyroid problem	□ yes □ no
Heart diseases	□ yes □ no	Cardiac pacemaker	□ yes □ no
Heart Murmur	□ yes □ no	Angina	□ yes □ no
Emphysema	□ yes □ no	Cancer	□ yes □ no
Arthritis	□ yes □ no	Artificial prosthesis(ie heart valve or joints)	□ yes □ no
Recent weight loss	□ yes □ no	Respiratory problems	□ yes □ no
Sexually transmitted Disease	□ yes □ no	Auto immune diseases	□ yes □ no
Stomach troubles/Ulcers	□ yes □ no	Chest pain	□ yes □ no
Easily Winded	□ yes □ no	Glaucoma	□ yes □ no
Tuberculosis	□ yes □ no	Radiation therapy	□ yes □ no
Liver disease	□ yes □ no	Hepatitis	□ yes □ no
Mitral Valve Prolapse	□ yes □ no	Type______	
Stroke	□ yes □ no	Hormone deficiency	□ yes □ no
Head or neck injuries	□ yes □ no		

11. **Are you allergic to or have you had any reaction to the following:**

Local Anesthetics	□ yes □ no	Sedatives	□ yes □ no
Penicillin or any other Antibiotics	□ yes □ no	Iodine	□ yes □ no
Barbiturates	□ yes □ no	Aspirin	□ yes □ no
Latex Rubber	□ yes □ no	Any metals	□ yes □ no
Codeine	□ yes □ no	Other	□ yes □ no
Fluoride	□ yes □ no	any other medicine	□ yes □ no

Name ______________________

Date ______________________

Diagnosis

Five Key Questions

1. Do you have trouble chewing gum?
   - Possible constricted chewing envelope
   - Note: Small piece not wad

   Yes ☐ No ☐

2. Do you have trouble chewing bagels?
   - Possible dysfunction
   - Note : Substitute dry chewy food

   Yes ☐ No ☐

3. Have your teeth changed in the last five years?
   - Ask wear/ shorter or thinner
   - Looseness / mobility
   - Open spaces
   - Indicates problem active not adapted

   Yes ☐ No ☐

4. Do you have more than one bite?
   - Possible dysfunction

   Yes ☐ No ☐

5. Do you have trouble with sleep?
   - Consider sleep bruxism

   Yes ☐ No ☐

12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? □ yes □ no
13. Women only:
    - Are you pregnant or think you may be pregnant? □ yes □ no
    - Are you nursing? □ yes □ no
    - Are you taking oral contraceptives? □ yes □ no
14. Name and address of your physician ______________________

PATIENT DENTAL HISTORY

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

1. Unhappy with the appearance of your teeth □ yes □ no
2. Unfavorable dental experiences □ yes □ no
3. Dental fears □ yes □ no
4. Problems with effectiveness or bad reaction to dental anesthetic □ yes □ no
5. Orthodontic treatment when ________ □ yes □ no
6. Periodontal (gum) treatment when__________ □ yes □ no
7. Bleeding gums □ yes □ no
8. Avoid brushing any part of your mouth □ yes □ no
9. Part of your mouth is sensitive to temperature □ yes □ no
10. Sore teeth □ yes □ no
11. A burning sensation in your mouth □ yes □ no
12. Difficulty swallowing □ yes □ no
13. An unpleasant taste or odor in your mouth □ yes □ no
14. Dry mouth, throat, and or eyes □ yes □ no
15. Jaw problems (temporomandibular joint) □ yes □ no
16. Difficulty opening your mouth widely □ yes □ no
17. Stiff neck muscles □ yes □ no
18. Awaken with an awareness of your teeth or jaws □ yes □ no
19. Tension headaches □ yes □ no
20. Clench or grind your teeth □ yes □ no
21. Jaw clicking or popping □ yes □ no
22. Lost any teeth □ yes □ no
23. Do you sweat or tremble a lot during examination □ yes □ no
24. Do strange people make you afraid □ yes □ no
25. Do you feel pain to any of your teeth □ yes □ no
26. Do you like your smile □ yes □ no
27. Do you have problems with bad breath □ yes □ no
28. Would you like your silver fillings replaced with white ones □ yes □ no

I have reviewed my medical/dental history date______________

Signature____

(For new patients)

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires this office to comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for a payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosure of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

____________________ ____________________

Patient Signature Patient Name (please print)

Date:________________

For Office use only

Patient Refused to Sign_

Circumstance or emergency situation that prohibited/prevented patient from signing the Acknowledgement.

____

________________ ________________ Date:____________

Office Personnel (signature) Office Personnel (print name)

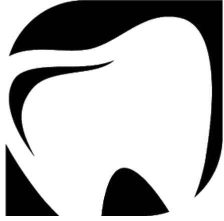
Please sign this form below under the heading "Consent" to consent to our disclosure of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

____________________ ____________________

Patient Signature Patient Name (please print)

Date:________________



ALISON B. LUBYANSKY DDS
FAMILY & COSMETIC DENTISTRY

Appointment Cancellation Policy
Effective as of March 1st, 2020

We are fully committed to providing exceptional care of the highest standard. Unfortunately, when one patient cancels without giving sufficient notice, they prevent another patient from being helped.

We understand life happens- and we will take your situation into consideration. We will do our best to accommodate your circumstances with empathy, but please remember we do track all occurences to prevent abuse of the policy.

Please call us at (248) 476-9121 by 1:00 p.m. on the day prior to your scheduled appointment to notify us of any changes. To modify a Monday appointment, please call us by 1:00 p.m. Thursday of the prior week. If prior notification is not given, you will be charged $50 for the missed appointment.

Thank you for your cooperation and understanding of this policy. It exists to maintain our commitment to comfort, honesty and quality. We respect your time and the time of our dental team. We appreciate your help in providing exceptional dental care.

By signing below, I certify and agree that I have read and understand the cancellation policy and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice.

____
Print Name (Please print)

______________________________ ____________________
Patient Signature **Date**