Dr. Feeney and the entire team at Copper Ridge Dental would like extend a heart-felt welcome!

Patient Information:

Name: DOB:

What do you prefer to be called?

Street Address:

City: State: Zip:

Mailing Address (if different):

Home phone: Work phone: Cell or pager:

E-mail address:

Social Security Number:

Marital Status(please circle): Single Married Divorced Minor

Your Employer: Work Address:

Spouse's Name: Spouse's DOB: Spouse's Employer:

Emergency Contact: Contact Number:

Is there someone we can thank for referring you ?

Responsible Party (if patient is a minor):

Person responsible for account: Relationship to patient:

Address (if different than patients):

Home phone: Work phone: DOB:

Social Security Number: Employer:

Insurance (Cardholder's Information):

Primary Dental Insurance:	Secondary Dental Insurance:
Name of Insured:	Name of Insured:
Date of Birth:	Date of Birth:
Insurance Company:	Insurance Company:
Subscriber ID:	Subscriber ID:
Group #:	Group #:

We record all insurance benefit information when provided with a current card. However, when your dental benefits change, we are not notified of those charges. It is your responsibility to keep track of any benefits used and to know what your coverage is. Please assist us in our quest to deliver ongoing exceptional service to you by alerting us of any changes in employment, insurance, marital status or address change.

I authorize the release of any dental information necessary to process all claims and release payment of dental benefits to my physician.

Signature: Date:

Brian N. Feeney, DDS, PC 4020 Copper View Suite 200 Traverse City, MI 49684

Patient Name_____

Physician:_____ **Emergency Contact:** _____

	Yes	No		Yes	No
Are you under medical treatment now?			Are you allergic to or have you had any reaction to the following?		
Have you ever been hospitalized for any Surgical operation or serious illness?			Local Anesthetics (eg. novocaine)		
Are you taking any medications,homeopathic& non-prescription medicine? List Below			Penicillin		
			OtherAntibiotics		
Do you use tobacco?			Sulfa Drugs		
Are you wearing contact lenses?			Barbiturates		
Women Only:			Sedatives		
Are you pregnant or think you may be pregnant?			Iodine		
Are you nursing?			Aspirin		
Are you taking birth control pills?			Other		

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

	Yes	No		Yes	No		Yes	No
AIDS or HIV infection			Cardiac Pacemaker			Radiation / Chemotherapy		
Anemia			Heart Attack			Stomach Troubles		
Hemophilia			Heart Disease			Thyroid Problems		
Hepatitis/Jaundice			Heart Murmur			Ulcers		
Kidney Disease			Heart Trouble			Acid Reflux Disease		
Leukemia			High Blood Pressure			Glaucoma		
Liver Disease			Low Blood Pressure			Diabetes		
Emphysema			Rheumatic Fever			Epilepsy		
Respiratory Problems			Stroke			Convulsions/Seizures		
Tuberculosis			Swollen Ankles			Fainting		
Asthma			Artificial Heart Valve			Seizures		
Allergies			Mitral Valve Prolapse			Joint Replacement: Date_____		
Cancer			Angina			Arthritis		

Patient Dental History

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?			Do you have frequent headaches?		
Are your teeth sensitive to hot or cold fluids / foods?			Do you clench or grind your teeth?		
Do you feel pain in any of your teeth?			Have you ever experienced any of the following problems in your jaw?		
Do you have any sores or lumps in your mouth?			a) Clicking?		
Have you ever had any difficult extractions?			b) pain (joint, ear, side of face?		
Have you ever had any prolonged bleeding following extractions?			Difficulty in opening or closing?		
Have you had any head, neck or jaw injuries?			Difficulty in chewing?		

Current Medications (Please include all homeopathic/herbal medications you are taking)_____

_____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health

X _____ **Date:**_____

Signature of patient or parent/guardian if minor

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Consent for use and disclosure for Treatment, Payment & Healthcare Operation
Right to Restrict and/or Revoke Authorization

Patient name: _____

Section A: Consent for Treatment, Payment and Health Care Operations

I hereby consent for the use or disclosure of my individually identifiable health information to carry out treatment, payment or health care operations. This includes assignment of benefits.

This consent is authorized for the following:
Family Physician, Family Hospital, Other Dental Specialist, Insurance Company, Immediate Family Members. If you wish to deny consent to any of these providers/individuals, please list under restrictions. Please list any additional providers/individuals you wish to include:

_____

_____

_____

I understand that I have the right to review this office's Notice of Information Practices.
I have received a copy of the Notice of Information Practices posted in this office and understand its meaning.
I understand that I have the right to request that this provider restrict how protected health information is used or disclosed to carry out treatment, payment or healthcare operations, and that the provider is not required to approve requested restrictions.
I have the right to revoke the consent in writing except to the extent that the provider has taken action prior to the revocation.
I understand that this authorization is voluntary.

List Requested Restrictions **Approved/Denied by Provider**

_____

_____

Specific description of information (including date(s):

_____

_____

X_____

Signature of patient or patient's representative **Date**
(Form must be completed before signing.)

Printed name of patient's representative:

_____

Relationship to patient:

_____

I want to revoke my authorization for treatment, payment, and health care operations beginning on _____,

Signature of patient or patient's representative: **Date**

§164.506 §164.532

Our Financial Summary

We are committed to providing you with the best possible professional care. This care can be furnished only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our billing or financial policies with our staff.

Insurance
We participate with BCBS, Delta Dental of MI, Delta USA, and Cigna. Participation means that we will submit the claim for you and accept assignment on covered services. You are responsible for applicable co-pay and deductible amounts at the time of service.

For patients with insurance we do not participate with, payment is also required at the time of service for all procedures. We will submit a claim to your insurance carrier on your behalf. Please understand any amounts not paid by your insurance company are your responsibility.

Credit Cards
For your convenience, we do accept VISA, MasterCard, Discover, and American Express credit cards.

Financing Plan
We also offer financing through Care Credit. Please ask an office team member if you need more information or an application.

Cancellation Policy
If you are unable to keep your appointment, please call the office 24 hours in advance. If you fail to come to a confirmed appointment, for either the doctor or the hygienist, please be aware that your account will be charged a nominal fee. This will not be billed to your insurance, but to your personal account.

Please keep in mind that your insurance is a contract between you, your employer, and the insurance company itself. Our fees are considered usual, customary and reasonable (UCR) by most companies. Some insurance companies arbitrarily select certain services that they will not cover. We must emphasize that our relationship is with you, not your insurance company. While filing insurance claims is a courtesy that we extend our patients, all charges are your responsibility from the date that services are rendered. **We attempt to keep informed and up to date on your benefits, but if/when your benefits change, we need to be notified by you of that change. Unfortunately, we are not notified by your insurance company.** It is the patient's responsibility to keep track of benefit levels and coverage. If you have any questions about the above information, please do not hesitate to ask. We are here to assist you.

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.

Signature_____Date_____