Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Phone (____) _____ Alt. Phone (____) _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS: List medications you are currently taking:

ALLERGIES

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Robert C. Masi, D.D.S. P.C.

Cosmetic & Family
Dentistry

Written Financial Policy Effective 01/01/2013

Thank you for choosing **Dr. Robert Masi D.D.S PC**. Our Primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

You can choose from:

-Cash, check Visa, MasterCard, Discover, or American Express

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $1500 or more.

-Convenient monthly payment plans offered by CareCredit

*Allows you to pay over time
*No annual fees or pre-payment penalties
*Offers no interest if paid in full within promotional period

Dr. Robert Masi D.D.S PC **requires payment prior to the completion of your treatment.** If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.
*For plans requiring multiple appointments, alternative payment agreements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. We do treatment plans to show you an **Estimate** of what your dental insurance will cover for treatment. This is **NOT** a guarantee of payment but we thrive to be as accurate as possible. Your insurance will make their final determination when they receive the claim.

We do require a 48-hour notice for any cancelling or rescheduling of appointments. There will be a minimum $50 charge for any missed or cancelled appointment made within the 48-hours. We ask that you are committed to your appointments as Dr. Robert Masi D.D.S PC is committed to your oral health.

Dr. Robert Masi D.D.S PC charges $35 for returned checks. Balances older than **60** days will be subject collection fees and finance charges at 1.5% per month. Balances **OVER 90** days will be sent to an outside collection agency that will affect your credit.

If you have any questions, please do not hesitate to ask. We are here to help you get the smile you deserve.

Patient, Parent, or Guardian Signature Date

Please Print Name

25630 Little Mack St. Clair Shores, MI 48081 Phone: 586.285.5758 Fax: 586.285.5410

Robert C. Masi, D.D.S. P.C.

Cosmetic & Family Dentistry

The Practice of: Dr. Robert Masi Acknowledgement of Receipt of this Practices Privacy Notice.

I acknowledge that I have received, and/or reviewed the notice of the Privacy Practices of this office. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that this notice of Privacy Practices is posted in the office where I can review it if desired.

_____

Patient name

X_____ _____

Patient Signature or Parent (If under 18) **Date**

I authorize my information (Example: Appointment details, treatment, and billing questions) to be released to the following individuals:

_____

_____

Signature:_____ **Date:**_____

Documentation of "Good Faith Effort"

Patient Name: _____ **Date**:_____

The patient presented for treatment on this date, and was provided the Practices Privacy notice. A good faith effort was made to obtain written acknowledgement of receipt. A written acknowledgement was not obtained because:

____ ***Patient refused to sign due to:***

_____

____***There was a medical emergency preventing timely signature, and an attempt will be made to obtain later.***

25630 Little Mack St. Clair Shores, MI 48081 Phone: 586.285.5758 Fax: 586.285.5410