White Pearl Dentistry

White Pearl Dentistry
203 S Zeeb Rd Ste 201
Ann Arbor, MI 48103
734-222-0055
smile@whitepearldentistry.com

New Patient Form

Patient Information

First Name:	M.I.:	Last Name:	Marital Status (circle one): M S Other:

Sex:	Date of Birth:	Social Security #:	E-mail Address:

Home Phone:	Work Phone:	Cell Phone:

Best times to contact you:	Send appointment reminders via: ❏Text Message ❏Email

Home Address:	City:	State:	ZIP Code:

Employer's Name:	Occupation:

Address:	City:	State:	ZIP Code:

Please tell us where you heard about us (check all that apply):

❏Friend or Relative (name): ❏Saw our Office ❏Insurance Company

❏Our Website ❏Search Engine (Google, etc.) ❏Other:

Was our website a factor in your decision to visit our practice? ❍Yes ❍No

Emergency Contact: *This should be the nearest relative who does not live with the patient.*

First Name:	Last Name:	Relationship to Patient:	Phone:

Spouse Information

First Name:	M.I.:	Last Name:	Date of Birth:

Social Security #:	Work Phone:	Cell Phone:	E-mail Address:

Employer's Name:	Occupation:

Address:	City:	State:	ZIP Code:

Insurance Information

Primary Insurance (Please Provide Insurance Card):

Name of Insurance:	Member ID:	Group ID:

Secondary Insurance (Please Provide Insurance Card):

Name of Insurance:	Member ID:	Group ID:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize White Pearl Dentistry to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to White Pearl Dentistry. I permit a copy of this authorization to be used in place of the original. I give White Pearl Dentistry, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature:	Date:

White Pearl Dentistry

White Pearl Dentistry
203 S Zeeb Rd Ste 201
Ann Arbor, MI 48103
734-222-0055
smile@whitepearldentistry.com

Name:

Dental History

Last dental visit?	Purpose:
Has fear or discomfort kept you from regular visits? ❑Yes ❑No	How would you describe your present dental health? ❑Good ❑Fair ❑Poor
Do you think you have active dental disease: Decay: ❑Yes ❑No Gum Disease: ❑Yes ❑No	Home care: Brush: ❑Yes ❑No Floss: ❑Yes ❑No
Do your gums ever bleed? ❑Yes ❑No How often?	Are you troubled with bad breath? ❑Yes ❑No
Do you like your smile? ❑Yes ❑No If no, describe:	History of smoking/chewing tobacco? If yes, describe: Interested in quitting? ❑Yes ❑No

Are you interested in any cosmetic improvements in your smile or want to learn more about bonding, veneers, and implants, replacing old fillings, or bleaching? ❑Yes ❑No Describe:

Have you ever had any unusual effects from previous dental treatment? ❑Yes ❑No Describe:

Medical History

Medical Doctor's name:	Last Physical Exam:	Phone:

Women: Are you pregnant? ❑Yes ❑No How long?

Are you under a doctor's care now? ❑Yes ❑No If yes, for what?

Are you taking any medications, pills, drugs? ❑Yes ❑No Please list:

Have you ever had any of the following?

❑Yes ❑No Arthritis	❑Yes ❑No Heart Trouble	❑Yes ❑No Stroke
❑Yes ❑No Asthma	❑Yes ❑No Hepatitis	❑Yes ❑No Prolonged Bleeding
❑Yes ❑No Cancer	❑Yes ❑No Herpes	❑Yes ❑No Prosthetic Joints
❑Yes ❑No Diabetes	❑Yes ❑No HIV or AIDS	❑Yes ❑No Psychiatric Care
❑Yes ❑No Epilepsy	❑Yes ❑No High Blood Pressure	❑Yes ❑No Tuberculosis
❑Yes ❑No Glaucoma	❑Yes ❑No HPV	❑Yes ❑No Migraine
	❑Yes ❑No Jaundice	❑Yes ❑No Other:

Have you ever had any other serious illness? ❑Yes ❑No Explain:

Have you been hospitalized in the last two years? ❑Yes ❑No Why?

Drug Allergies ❑Yes ❑No Please list:

Do you wish to talk to the doctor about any problem not listed? ❑Yes ❑No

Comments:

Signature:	Date:
Office Use: Doctor's Signature:	Blood Pressure:

White Pearl Dentistry

White Pearl Dentistry
203 S Zeeb Rd Ste 201
Ann Arbor, MI 48103
734-222-0055
smile@whitepearldentistry.com

Consents

Insurance

WPD provides insurance company billing as a *courtesy* to our patients. The patients portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjusted by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each year plan. If you or your family exceed these annual limitations in any plan year you will be responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The claim we submit to insurance companies indicate that you have assigned those benefits to WPD. However, if you are paid by the insurance company instead of WPD, you then become responsible for the maximum benefits available. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You, as a patient, are always responsible for any charges that are not covered by your insurance. The patient may not rely upon any information provided by WPD staff regarding his/her remaining benefit in any such benefit period. Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay up to date with these changes, it is not always possible. **It is your responsibility to know your individual coverage.** We expect your co-payment at the time of service and will, in most cases, be willing to wait for the remaining insurance reimbursement. Please remember that **your** insurance policy is between **you and your insurance company** and **NOT** the insurance company and your doctor. You are ultimately responsible for the professional fees, co-pays and deductibles not covered by your insurance. Although we may provide you with an estimate for your treatment, this is just that, an **ESTIMATE**. In the event that insurance does not cover their expected portion, you are responsible for the full amount.

Service Charges

Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of $10 per month (or a minimum charge of $10 for a minimum balance of $25.00) which is an annual percentage rate of 0% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. Personal checks that are returned due to "insufficient funds" are subject to a $35.00 service fee.

Adults and Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment.

This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Internet Communication

I grant my permission to White Pearl Dentistry to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for White Pearl Dentistry. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand White Pearl Dentistry and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that White Pearl Dentistry is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand White Pearl Dentistry is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the White Pearl Dentistry web site with my ID and password. I also agree to immediately notify White Pearl Dentistry of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand White Pearl Dentistry will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that White Pearl Dentistry has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand White Pearl Dentistry will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand White Pearl Dentistry CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED; MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

No Show Policy

As a courtesy to other patients who wish to see the doctor as quickly as possible, please call to reschedule or cancel your appointment as soon as you know you will be unable to keep your appointment. If you contact our office more than 24 hours prior to your appointment, you will avoid the No Show Charge.
If you do not call to cancel your appointment more than 24 hours in advance**, you will be billed $35** for a missed re-care visit or **$75 for a missed procedure**. We do realize that on rare occasions, emergencies may arise and we will address these situations with you at that time. Our goal is to provide excellent care to our patients, the No Show Charge helps us insure efficient and effective scheduling appointments so that patients may be seen as quickly as possible. We ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. ALL MINORS MUST BE ACCOMPANIED BY AN ADULT. I ❑***Authorize*** ❑***Decline*** the use of my (Smile) photos before and after to be used on our website and in our before and after books located in the office, when I consent to cosmetic treatment. I understand that my face will not be shown only my teeth. I also understand that my name will not be placed with my picture.

Signature:	Date:

White Pearl Dentistry

White Pearl Dentistry
203 S Zeeb Rd Ste 201
Ann Arbor, MI 48103
734-222-0055
smile@whitepearldentistry.com

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully. The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.
- In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are: When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research, to prevent a serious threat to health or safety and for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information, relating to worker's compensation programs, of a "limited data set" for research, public health, or healthcare operations Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures, and to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of May 16, 2017, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S. Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human
Services Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

White Pearl Dentistry
203 S Zeeb Rd Ste 201
Ann Arbor, MI 48103
734-222-0055
smile@whitepearldentistry.com

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize White Pearl Dentistry to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

Additionally, I authorize you to share all my protected health information with the following individual(s):

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature:	Date:

If signing on behalf of someone, explain your relationship to the patient:

Acknowledgement of Receipt of Notice of Privacy Practices, Consent for Disclosure of Health Information and Informed Consent of General Dentistry

I have read the information above regarding the secured uploading of patient information to the website for White Pearl Dentistry, and grant White Pearl Dentistry permission to securely upload my patient information to the website.

By consenting to treatment you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less then optimal results. Please be sure to discuss with the dentist any risks or concerns you may have about any treatment.

I have read the above conditions of treatment and payment, and agree to their content.

I have received a copy of this offices Notice of Privacy Practices. Also by signing this form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I grant my permission to you or your assignee, to send me information through the mail & telephone me at home or at my work to discuss matters related to this form.

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 that revocation of this Consent will not affect any action we took in reliance on the 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:	Date:

If signing on behalf of someone, explain your relationship to the patient:

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.

The following circumstances prohibited the patient from signing the consent form:

Describe your good faith effort to obtain the individual's signature on this form:

Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date: