Novi Oaks Dental
Family & Cosmetic Dentistry

Dr. Anjoo Ely
27225 Providence Pkwy #100 Novi, MI 48375
Phone: 248.347.3030 | Fax: 248.347.1198
www.novioaksdental.com

PATIENT INFORMATION

Full Name: _____
Last First M.I.

Address: _____
Street Address APT/Unit #

_____
City State Zip Code

DOB: _____ SSN: _____ Gender: _____ Preferred Pronouns: _____

Marital Status: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Would you like to opt in to text message reminders and notifications? Y ☐ N ☐

Email: _____ How did you hear about us? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

DENTAL INSURANCE / PAYMENT

Do you have primary dental coverage? Y ☐ N ☐

Insurance Company Name: _____

Policy Holder Subscriber ID#: _____

Policy Holder Name: _____

Date of Birth: _____

Relationship to Policy Holder: _____

Do you have a secondary dental policy? Y ☐ N ☐

Insurance Company Name: _____

Policy Holder Subscriber ID#: _____

Policy Holder Name: _____

Date of Birth: _____

Relationship to Policy Holder: _____

I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to/necessary for the process of any dental claim or claims.

Patient/Guardian Signature: _____ Date: _____

We pride ourselves on giving you undivided attention during your visit with us. To do this we reserve your appointment time just for you. We value your time, and you can expect us to be on time for your appointment. We expect and appreciate the same courtesy. Occasionally emergencies can interrupt our schedule, and we do our best to call you if we know in advance. If it is unavoidable for you to reschedule your appointment, we require two business days' notice so that another patient has an opportunity to utilize the time reserved for you. **In absence of this required two day notice you will be charged a $50.00 broken appointment fee.**

Our front office team has extensive knowledge and experience with dental benefit plans, and is passionate about gaining the highest possible benefit from your plan for you. We cannot, however, guarantee payment on behalf of your benefit company. While we will do everything possible to gain payment on your behalf, it is important that you know *there is never a guarantee of payment from an insurance company until they issue payment, and you are ultimately responsible for any balance that may remain after insurance, including reimbursement to us any collection agency fees, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.*

I have read and agree to the above information, and have answered the above questions accurately.

Patient/Guardian Signature: _____ Date: _____

DENTAL / MEDICAL HISTORY

What is the reason for your appointment today? _____

Are you allergic to any of the following?
*Please answer (Y) YES or (N) NO

Y	N	
☐	☐	Aspirin
☐	☐	Barbiturates
☐	☐	Codeine
☐	☐	DentalAnesthetics
☐	☐	Erythromycin
☐	☐	Jewelry/Metals
☐	☐	Latex
☐	☐	Penicillin
☐	☐	Sedatives
☐	☐	Sulfa Drugs
☐	☐	Tetracycline

Other: _____

Are you currently under the care of a physician? Y ☐ N ☐

Please explain: _____

Pregnant? Y ☐ N ☐ Nursing? Y ☐ N ☐

Do you smoke or use tobacco in any form? Y ☐ N ☐

Are you taking any of the following?
*Please answer (Y) YES or (N) NO

Y	N	
☐	☐	Acetaminophen
☐	☐	Antibiotics
☐	☐	Antihistamines
☐	☐	Aspirin
☐	☐	Blood Thinners
☐	☐	Blood Pressure Medication
☐	☐	Cold Remedies
☐	☐	Digitalis/Heart Medication
☐	☐	Insulin/Diabetes Drugs
☐	☐	Nitroglycerine
☐	☐	Recreational Drugs
☐	☐	Steroids/Cortisone
☐	☐	Thyroid Medicine
☐	☐	Tranquilizers
☐	☐	Birth Control

Other: _____

Do you require antibiotics before dental treatment? Y ☐ N ☐

DO YOU HAVE OR HAVE YOU EXPERIENCED THE FOLLOWING? (Select all that apply)

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chicken Pox
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Daytime Sleepiness
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV+ or AIDS
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Persistent Cough
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Steroid Therapy
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

Have you ever been prescribed or are you currently wearing a C-PAP machine? Y ☐ N ☐

Do you now or have ever experienced pain or discomfort in your jaw (TMJ/TMD)? Y ☐ N ☐

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize Dr. Ely to perform the necessary dental services I may need.

Patient/Guardian Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 {"HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship (if other than the patient): _____

Signature: _____ **Date:** _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Staff Initials: _____ **Date:** _____

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WELCOME TO NOVI OAKS DENTAL

Welcome to our dental practice! We thank you for making us your choice and joining with us in caring for your dental health. By becoming a patient, you have created a partnership which we hope will last through the years.

Our partnership is prevention oriented and dedicated to your overall health. We are committed to providing superior dental care and are proud of our dedication to our patients. Our goal is to help you feel and look your best while focusing on long term dental health.

There are no regulations to how insurance companies determine reimbursement levels, resulting in wide fluctuation. In addition, insurance companies are not required to disclose who they determine these levels. We do expect you to know what your dental benefits are, and also expect you to understand that your insurance is your responsibility. Once treatment begins, payment is expected in full unless otherwise arranged. Our insurance coordinator will discuss financial arrangements and alternatives with you. She will also do her best to answer any questions you may have regarding your insurance.

We do value your time, and you may expect us to be on time with your appointment. We will expect and appreciate the same courtesy. Occasionally emergencies do interrupt our regular schedule of patients. If it is necessary for you to reschedule an appointment, we require notice of 2 business days so that the time reserved for you may be utilized by another patient. **Otherwise you will be charged a $50.00 cancellation fee**.

We welcome new patients and appreciate any referrals we might earn. Our practice again welcomes you and looks forward to a long and healthy partnership with you, your family and friends.

Best regards,

Anjoo C. Ely, D.D.S.

Patient/Guardian Signature: _____ **Date:** _____