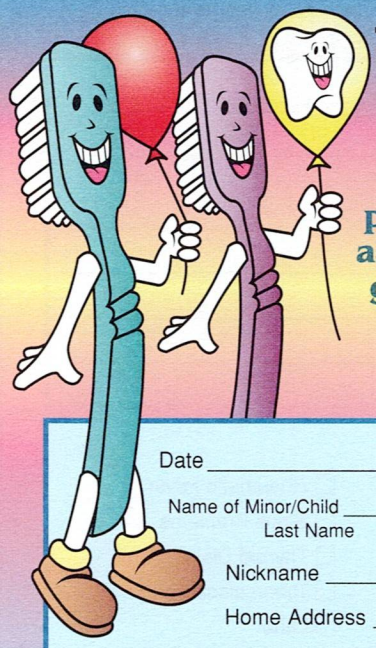
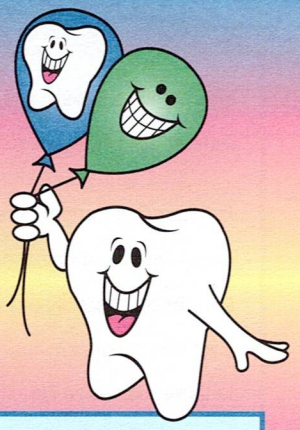


Welcome!



We are pleased to welcome you and your child 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 child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's / Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's / Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

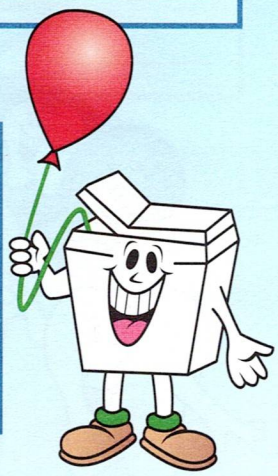
Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐



MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

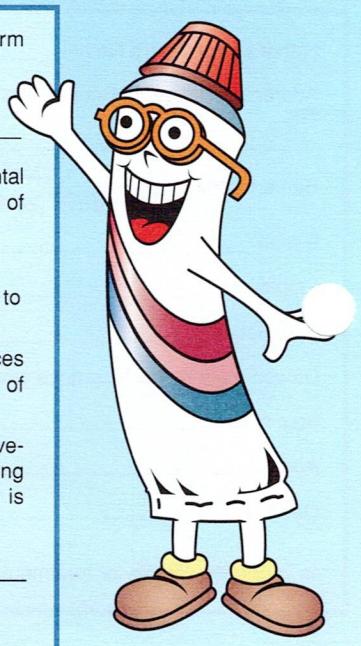
I certify that my dependent(s) is covered by insurance with _____ and assign directly to
Name of Insurance Company(ies)

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 doctor may use my minor/child's 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 the current treatment plan is completed or one year from the date signed below.

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

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



UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

Dr. Aimee Vakula-Rollins

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office 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.

From time to time it may be necessary for us to make disclosures of your information in connection with our 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 disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below to acknowledge that you have today either received or reviewed 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)

I am also signing for my minor children: _____

(please print names)

Date: _____

Patient Consent

Please sign this form below to consent to our disclosures 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)

I am also signing for my minor children: _____

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, care giver)

_____

(please print names)

_____

_____

I also give my permission for information regarding ____ treatment ____ appointments, ___ insurance benefits, ___ financial arrangements to be discussed with the above individuals.

Date: _____

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

_____ _____

Office Personnel (signature) Office Personnel (print name)

Date: _____

Dr. Aimee Vakula-Rollins

PATIENT COMMUNICATION PREFERENCES

To Our Valued Patients:

We are updating our records to determine the best way to communicate with you regarding treatment and appointments in our practice, as well as information regarding your dental health.

Please let us know your preferred method for receiving messages from us:

Cell phone – number: _____

Home phone – number: _____

Work phone – number: _____

Email: _____

In the event you cannot be reached directly by phone, is there someone we may leave a message with? (e.g. spouse, partner) Name: _____

Relationship: _____ Phone number: _____

May we send text messages to you regarding your appointments? Yes No

Please send text messages to (number) _____

May we send e-mail messages to you regarding your appointments? Yes No

In the future we may send electronic billing statements to you when applicable.

Would you like to receive electronic statements from our practice? Yes No

Would you like to receive electronic newsletters from our practice? Yes No

_____ _____

Name Signature

_____

Date

Aimee D. Vakula-Rollins, D.D.S., P.L.L.C.
FINANCIAL POLICY

Insured Patients:

Financial arrangements must be made *prior* to treatment.

- Your insurance is a contract between you, the insured, and the insurance company.
- Although your insurance may assist you with partial payment of your treatment, the ***estimated*** portion, which is not covered, is due when services are rendered.
- As a courtesy to our patients, we will bill your primary insurance company. If your insurance has not paid within 60 days, you will be billed for the entire balance and payment will be expected at this time. We will, however, continue to work with you or your insurance company to expedite your reimbursement.
- It is your responsibility to keep our office informed of any changes pertaining to your employment or insurance coverage.

The services rendered by this office will be coded according to the American Dental Association's guidelines and submitted electronically.

Payments may be made by any of the following methods, please indicate your method of below.

CASH_____ CREDIT CARD_____

CHECK_____ CARECREDIT_____

- I understand that my insurance may pay only a portion of the claim(s) submitted, and I am ultimately financially responsible, and I agree to pay for all expenses incurred for the services rendered by this office.

- I request that all insurance benefits be paid directly to Dr.Vakula-Rollins. If payment by the insurance company is made to the insured, I agree to endorse, or have the insured endorse the check, and/or make payment immediately to Dr.Vakula-Rollins. I further authorize the release of information to my insurance company necessary to determine liability for payment and to obtain reimbursement of any claim.

- A billing charge of 2.00% (per statement) will be applied to any unpaid portion of your balance.

- In the event that this account is assigned to an attorney or agency for collection and/or suit, I agree to pay the attorney's or agency's fees, court cost, and interest from the date of treatment.

- A charge of $25 will be applied to broken appointments (i.e. No shows or cancelled in less than 24 hours prior to the time of the appointment)

- A charge of $25 will be applied to all returned checks.

I understand and agree to all the above conditions of this Financial Policy.

_____ _____

Patient/Parent or Guardian (if a minor) **Date** **Soc. Sec. #**

(PLEASE TURN OVER AND COMPLETE OTHER SIDE)

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of

_____'s dental needs.
(print full name of patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient_____ _____ Date_____
Signature (if a minor, Parent or Guardian) Relationship to Patient

Dr. Aimee Vakula-Rollins, D.D.S.
1044 N. Irish Rd, Ste. B
Davison, Michigan 48423

X-Ray Consent for Minor

I give permission for _____ to have x-rays,and/or fluoride, as needed, at their appointment.

I further give permission for x-rays and/or fluoride, as needed, at future appointments.

I am the patient's parent / guardian.

(Please circle the one that applies)

_____	_____	_____
Print Name	Signature	Date