By the Sea
DENTISTRY
CHRISTOPH MICHEL, D.M.D.

235 Shore Road
Somers Point, NJ 08244
www.ByTheSeaDentistry.com
609-927-9300
fax 609-927-6117

Date_____

Patient Name _____Male__Female__Age__Date Of Birth_____Marital Status____

Social Security #_____Street Address_____

Po Box _____ City_____State_____Zip_____

Home Phone _____Cell Phone _____E-Mail _____

Patient Employer_____Address_____Phone_____

Position Held _____How Long Held _____Dental Insurance_____

Dental Insurance Name _____Group #_____ID#_____

Address_____Phone# _____

Name of Spouse _____Date of Birth _____ SS#_____ Phone#_____

Spouse Employer _____Address _____ Phone# _____

Dental Insurance Name _____Group #_____ID#_____

Address_____Phone# _____

Whom may we thank for referring you? _____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of service not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Patients or guardian's signature _____

Date _____

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Patient's Name: _____ DOB _____
Last First Initial

1. Physician's Name: _____
   Address: _____
2. Are you under a physician's care?.....Yes No
   Since when_____Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medications? _____Yes No
   _____
   _____

5. Do you routinely take health related substances such as vitamins?.....	Yes	No
6. Are you allergic to any medications?.....	Yes	No
7. Do you have any other allergies?.....	Yes	No
8. Are you sensitive to any metals or latex?.....	Yes	No
9. Are you pregnant or suspect you may be?.....	Yes	No
10. Have you ever been treated for or been told you have heart disease?.....	Yes	No
11. Do you have a pacemaker an artificial heart valve Implant?.....	Yes	No
12. Have you ever had rheumatic fever?.....	Yes	No
13. Are you aware of any heart murmurs?.....	Yes	No
14. Do you have high or low blood pressure?.....	Yes	No
15. Have you ever had a serious illness or major surgery?.....	Yes	No
If so, explain_____		
16. Have you ever had radiation treatment, chemo treatment for tumor, growth, or other condition?.....	Yes	No
17. Do you have inflammatory diseases, such as arthritis or rheumatism?.....	Yes	No
18. Do you have artificial joints/prosthesis?.....	Yes	No
19. Do you have any blood disorders, such as anemia, leukemia, etc?.....	Yes	No
20. Have you ever bleed excessively after being cut or injured?.....	Yes	No
21. Do you have any stomach problems?.....	Yes	No
22. Do you have any kidney problems?.....	Yes	No
23. Do you have any liver problems?.....	Yes	No
24. Are you a diabetic?.....	Yes	No
25. Do you have asthma?.....	Yes	No
26. Do you have epilepsy or seizure disorders?.....	Yes	No
27. Do you or have you ever had venereal disease?.....	Yes	No
28. Have you tested HIV positive or have AIDS?.....	Yes	No
29. Have you ever tested positive for hepatitis?.....	Yes	No
30. Do you or have you ever had TB?.....	Yes	No
31. Do you smoke, chew, use snuff or any other forms of tobacco?.....	Yes	No
32. Do consume alcoholic beverages?.....	Yes	No
33. Do you habitually use controlled substances?.....	Yes	No
34. Have you ever had psychiatric treatment?.....	Yes	No
35. Do you have any disease, condition, or problem not listed?.....	Yes	No

I certify that the above information is complete and accurate.

Patient's/Guardian's signature _____Date_____

Pain/Jaw

	Yes	No	
Do you have frequent headaches and earaches?			
Have you ever had any head, neck or jaw injuries?			
Have you experienced any of the following in your jaws? (Please circle all that apply) Clicking/Popping Pain in joint or ear Difficulty Opening Difficulty Chewing			

Please list any medical or dental questions or concerns you may have.

_____

_____

_____

Level of Treatment

We respect your right to choose the level of care that fits your needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply:

☐ I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good and last for a long time.

☐ Spreading payments out over time may help me to achieve the excellent results I desire.

☐ Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.

☐ I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.

☐ Although I am not interested in a plan for long-term dental health, I do desire an office that will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

☐ I have considered cosmetic dentistry.

COSMETIC / ESTHETIC EVALUATION

Are you delighted with your smile? ____Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = Awesome)

Would you like to have whiter teeth? Yes No

If you had a magic wand what, if anything would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Through state of the art technology of Cosmetic Dentistry, we have the ability to help you achieve a World-Class Smile, often overnight…
Using computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile?
Yes No If yes, please check off all that apply:

	Lighten all front teeth showing
	Lighten single tooth
	Close spaces between teeth
	Rebuild fracture(s)
	Lengthen
	Shorten
	Lighten all front teeth showing
	Lighten single tooth

	Close spaces between teeth
	Straighten rotation
	Straighten angulation
	Eliminate crowding
	Eliminate dark or stained fillings
	Reduce gum showing in smile
	Repair uneven edges

Please add anything you feel is important: _____

_____

Patient's Financial Responsibility Statement

We reserve the right to charge a $50.00 fee for any appointments cancelled without a 48-hour notice and a $75.00 fee for any "NO SHOW" appointments since our office is scheduled by appointment only.

All dental care insurance carriers or payers of dental benefits may pay less than the actual bill for services. Therefore, you are financially responsible for payments in full of all accounts. By signing this financial agreement responsibility statement, you revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or in part by the dental care payer.

All costs necessary to collect any balance which remains unpaid for more than 30 days, including attorney's fees, which shall be calculated at one-third (1/3) of the original amount due and which shall accrue upon commencement, shall be your responsibility.

I have read and understand and agree to the above information.

Patient or Guardian's Signature _____

Date _____

Certification of Military Status

I, _____ hereby certify under penalty of perjury, that I AM_____AM NOT _____ (check one) in the active military service (including the Army, Navy, Air Force, Marines, Coast Guard and/or National Guard) of the United States of America. I further certify that, if the above status should change, I shall immediately notify your office in writing of the change.

Patient or Guardian's Signature _____

Date _____

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 its *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 Privacy 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 to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

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

Date:	Initials:	Reason: