Michael D. Dienes, D.D.S.
Gregory J. Franklin, D.D.S.
Michael J. DeLeeuw, D.D.S.
DENTAL

WELCOME TO MGM DENTAL

The doctors and staff of MGM Dental would like to take this opportunity to welcome you to our practice and thank you for choosing us for your dental care needs.

Enclosed you will find your pre-registration forms. Please review and complete, sign and date these forms prior to your visit and bring them with you for your appointment.

Along with these forms we will also require:

- Dental insurance card(s)
- Valid driver's license
- List of medications you are currently taking
- Any recent x-rays from previous dentist, if available

We should have already discussed and checked into your insurance coverage at the time you scheduled your appointment. Please note that any and all co-pays are due at the time of service. We accept cash, Visa, MasterCard, Discover, American Express and CareCredit.

Keep in mind that most plans pay on their own customary fees which may vary from our fees. After insurance pays, there may be an additional co-pay owing.

The financial obligation for dental treatment is between you and our office. The insurance company is responsible to you and not our office. We will accept payments from the insurance company on your behalf and assist you in any way we can. Once your carrier has paid the claim, any additional difference will be billed to you accordingly.

We are looking forward to your visit. If you have any questions or concerns, please feel free to contact our office.

Appointment date : ____________________ Time: ____________

Office Location: ______________________ Office Phone: ______________

MGM DENTAL

PATIENT INFORMATION

Patient Name____ Date of Birth__________________

Address_______________________________City____________________ State_______ Zip_________

Home#_______________________ Work#________________________ SS#_______-______-_______

Are you a full time student? ____________________ If YES, Where?____________________________

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Patient/Guardian Name____Relationship______________________

Address________________________________ City________________ State________ Zip__________

Home#_______________________ Work#______________________ SS#_________-______-________

INSURANCE INFORMATION

	PRIMARY	SECONDARY
Employee Name	________________________	________________________
Employee Date of Birth	________________________	________________________
Employer Name	________________________	________________________
Employer Phone #	________________________	________________________
Name of Insurance	________________________	________________________
Policy/SS#	________________________	________________________
Group/Local#	________________________	________________________

IN CASE OF EMERGENCY

Name_________________________________Phone#______________________Relationship__________

WHO MAY WE THANK FOR REFERRING YOU TO US? ______________________

I will be paying today by: Cash______ Check______ Credit Card______

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

SIGNATURE____**DATE**__________

Michael D. Dienes, D.D.S.
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DENTAL

MEDICAL HISTORY

DATE:________________

PATIENT'S LEGAL NAME________________________________ HOME PHONE:________________

FAMILY PHYSICIAN________________________ PHONE:____________ DATE OF LAST PHYSICAL__________

HEIGHT______________ WEIGHT______________ DATE OF BIRTH______________

Yes	No	
☐	☐	Have you ever been hospitalized? Reason for hospitalization / medical treatment:________________
☐	☐	Are you currently being treated by a physician? Reasons:________________
☐	☐	Are you currently taking any drugs or medications (including birth control pills)? Name drugs and reason for use:________________
☐	☐	**Do you have any Allergies or Sensitivities?**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Erythromycin
☐	☐	Penicillin
☐	☐	Others
		Do you have or have you ever had:
☐	☐	Arthritis
☐	☐	Artificial Joint Replacement
☐	☐	Asthma, Emphysema, Lung, Breathing Problems, Shortness of Breath
☐	☐	Pneumonia
☐	☐	High Blood Pressure
☐	☐	Blood Diseases, Anemia, Hemophilia, Bruise Easily
☐	☐	Diabetes, Slow Wound Healing
☐	☐	Ear Infections, Hearing Aid
☐	☐	Epilepsy, Fainting Spells, Seizures
☐	☐	Heart Attack, Disease, Pains, or Surgery
☐	☐	Heart Murmur, Rheumatic Fever, Valve Surgery, Pacemaker, Mitral Valve Prolapse
☐	☐	Are you currently in good health?
		Infectious Diseases:
☐	☐	AIDS (Are you in a possible risk category?)
☐	☐	Drug use involving needles
☐	☐	Hepatitis A (infectious)
☐	☐	Hepatitis B (serum)
☐	☐	Herpes
☐	☐	Tuberculosis
☐	☐	Venereal Disease (Syphilis, Gonorrhea)
☐	☐	Are you pregnant?
☐	☐	Psychiatric care or medications, nerve medication
☐	☐	Steroid drugs or therapy
☐	☐	Stomach problems, Bulemia, Ulcers
☐	☐	Thyroid
☐	☐	Tumors or Growths
☐	☐	Radiation or Chemotherapy
☐	☐	Is there any other health problem(s) we should be aware of?

I AGREE THAT THE ABOVE INFORMATION IS TRUE.

________________________________ ________________
Signature Date

Notes & Medical History Updates:________________________________

GREGORY J. FRANKLIN, DDS AND ASSOC., PC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003,and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment
to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provide performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Michigan Consent Law: Your consent may also be required in order for this office to make uses and disclosures of your health information if required by Michigan Law.

Your Authorization: In addition to our use of your health information for treatment,payment of healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocations will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written consent.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing).** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: Your have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Privacy Officer

Telephone: (586) 263-4720 E-mail: gjfranklin-dds@prodigy.net

Fax: (586) 263-0237 Address: 39400 Garfield, Suite 100 Clinton Township, MI 48038

MGM DENTAL
39400 Garfield
Suite 100
Clinton Twp, MI 48038

{NAME OF PRACTICE}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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