All Brite Laser Dentistry

22190 GARRISON, SUITE 205
WEST DEARBORN, MI 48124

Medical Alert For Office Use

Patient Information

Name ____
LAST FIRST MIDDLE INITIAL NICKNAME

Address ____
STREET

____
CITY STATE ZIP E-MAIL

Employer ______________________ Drivers License ______________________

Birth date ______________________ Height ____________ Weight ____________

Phone: Home (____) ______________________ Social Security # ______________________

Work (____) ______________________ ❑ Male ❑ Female

Mobile(____) ______________________

Emergency: Name ______________________ Phone (____) ______________________

Medical History and Information

Do you have or have you ever had?

- ❑ Arthritis
- ❑ Artificial joints
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Depression
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Sexually Transmitted Diseases
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other ______________________

Are you allergic to?

- ❑ Aspirin
- ❑ Barbiturate
- ❑ Codeine
- ❑ Penicillin
- ❑ Other ______________________

Are you currently under the care of a physician?

❑ Yes ❑ No

PLEASE EXPLAIN & LIST ANY **MEDICATIONS**

____
____
____
____
____
____

Female patients: Are you pregnant? _____ #months_____

DO YOU PRE-MEDICATE WITH ANTIBIOTICS BEFORE DENTAL TREATMENT? YES NO

If Patient is Under 18

Responsible Party ______________________ Relation to Patient ______________________

Address ____
STREET

____ (____)
CITY STATE ZIP TELEPHONE

Other Information

How did you hear about us? ____________________

What was the reason for today's visit? ____________________

Concerns we can help you with today? ____________________

____

Have your teeth ever embarrassed you? ____________________

Do you love your smile? ____________________

Is there anything you would like to change? ____________________

Why did you leave your last dentist? ____________________

What did you like *most* about your last dentist? ____________________

What did you like *least* about your last dentist? ____________________

Do you have frequent headaches? If yes when? ____________________

Are your teeth sensitive to hot, cold or biting? ____________________

When was your last cleaning? ____________ Have you ever had a "deep" cleaning before? ____________

Do your gums bleed? ______ Have you ever had gum surgery before? When? ____________

Do your parents have their teeth? ____________________

Insurance

Primary Carrier

Subscriber Name ____________ Social Security # ____________ DOB ____________

Employer ____________ Insurance Co. ____________

Insurance Co. Phone # ____________ Group # ____________

Relation to patient ____________

Secondary Carrier

Subscriber Name ____________ Social Security # ____________ DOB ____________

Employer ____________ Insurance Co. ____________

Insurance Co. Phone # ____________ Group # ____________

Relation to patient ____________

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Zia Rafiq, DDS, (DBA All Brite Laser Dentistry) of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs for dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature X ____________________ Date ____________

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

X ____________________ ____________

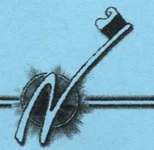
PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

____________________ ____________

PARENT/GUARDIAN SIGNATURE DATE

ALL BRITE LASER DENTISTRY



22190 GARRISON, SUITE 205
WEST DEARBORN, MI 48124

FINANCIAL POLICY

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

We will bill your insurance company, if the services provided to you are covered by your insurance. **You are required to pay the deductible and co-payment at the time of treatment. However, you remain responsible for the balance of the charges if your insurance company does not pay.**

Financial arrangements are available if the estimated portion of your charges is $200 or more and you can not pay it in full at the time of service. We offer several payment plan options, please ask front desk for details.

To maintain practice operations and to prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. Payments are expected at the time services are rendered. **We accept cash, checks, debit cards and all major credit cards.**

<u>Broken appointments:</u> Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, **we require at least 24 hours notice** to avoid a $75.00 cancellation fee. (emergencies are an exception).

X_________________________________ DATE: ____________________

Patient or Legal Guardian Signature

__________________________________ DATE: ____________________

Representative of the Dentist (witness)

ALL BRITE LASER DENTISTRY

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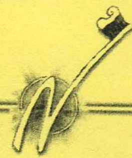
WEST DEARBORN, MI 48124



ABOUT YOUR INSURANCE

At **All Brite Laser Dentistry**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but most don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know…

Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly.**

Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of $1,000. You'll be surprised to know today that the average dental benefit plan has a yearly maximum cap of $1,000. **There has been no significant increase in the yearly maximum cap in 40 years!** However, there have been significant increases in your premiums. **Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. **Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."**

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum or limitations. It is more realistic to expect dental benefit plans to cover between 25% to 40% of dental services. **Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan.** You will get back only what your employer has put in, less the insurance company's profit margin.

Insurance companies do NOT cover many routine and newer dental services. We bill your insurance as a courtesy. If insurance does not pay within **60 days, All Brite Laser Dentistry** reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a **legal contract between YOU and YOUR insurance company.** Our office **is not**, and **cannot** be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. We hope you will choose the best that dentistry has to offer.

*I have read, understand, and accept the terms of the above outlined policies for insurance and financial commitments that may incur as a result of treatment at **All Brite Laser Dentistry.***

X____

Signature *Date*

ZIA RAFIQ, DDS, PLLC

22190 Garrison St., Suite 205, Dearborn, MI 48124

(313) 562-3388

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 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.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosure in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your 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.

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy ____________________

Patient Acknowledgement

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

X______________________________ X______________________________ Date: ______________

Patient Signature   Patient Name (Please Print)

For Office Use Only

_______ Patient Refused to Sign

_______ An emergency situation prevented the patient from signing the Acknowledgement

The following circumstances prohibited the patient from signing the Acknowledgement:

____

______________________________ ______________________________ Date: ______________

Office Personnel (Signature)   Office Personnel (print name)

Please sign this form below under the heading "Patient Consent" to consent to our disclosure of your information that we deem necessary in order to provide you with proper treatment.

Patient Consent

I consent to your disclosure of my information, which you deem are necessary in connection with my treatment. I understand that such disclosure may not be of the type listed above.

X______________________________ X______________________________ Date: ______________

Patient Signature   Patient Name (pleases print)