Pesis Dental Group, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

_____
Please Print Name

_____
Signature

_____
Date

Children:

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 _____

Patient Consent

Please sign this form below under the heading "Consent" 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 _____

Print Name _____ Date: _____

29224 W. EIGHT MILE ROAD
FARMINGTON HILLS, MI 48336
PHONE: (248) 478-1650

Pesis Dental Group

Hello,

Our dental team is happy to welcome you (and your family) to our practice! We are pleased that you have chosen us to help care for your oral health. We want you to know that our dental team is committed to providing you with the highest quality of dental treatment, and we will do so in a gentle, efficient, and knowledgeable manner.

The first visit to our office will consist of a complete oral examination. We will be taking x-rays and performing any other tests that are needed to make a complete diagnosis of the condition of your mouth, teeth, and gums. We will then be able to determine the treatment options and present them to you. Incomplete care leads to further disease and loss of teeth. Incomplete treatment leads only to further complications and misunderstandings. Therefore, all will agree to the treatment plan. Once treatment is started it should be completed.

We will always make an effort to consider your time valuable. Emergencies however, do occur. So on occasion, we may need you to be understanding of our situation. If an emergency does happen to come up, we will always try to be as prompt as possible. We would appreciate your being prompt also. Your appointment written in our schedule is a bond of trust that we will be here to serve you and you will be present for that time. We charge for all no show or cancellations made less than 48 hours in advance. Your needed signature below indicates that we must have mutual respect for each other's time.

_____

Your Signature Here

Our payment policy is: Cash, Check, Visa or Mastercard at the time of treatment.

Please fill out and bring the enclosed health questionnaire to your first appointment. This is to ensure that we provide the most complete, careful, and concerned attention you deserve!

If you have any questions or an emergency, please give us a call. Otherwise, we look forward to seeing you at your scheduled time.

Sincerely,

Dr. Jacob Pesis
Dr. Solomon K. Pesis

29224 W Eight Mile Rd.
Farmington Hills, MI 48332

Pesis Dental Group, P.C.

Bus: (248) 478-1650
Fax: (248) 478-2166

Name_____Birthdate_____SS#_____Phone #_____

Address_____City_____State_____Zip_____

Occupation_____Employer_____Bus. Phone #_____

Driver's License #_____

Responsible Party_____SS#_____Birthdate_____

Dental Ins._____

Spouse Name_____Birthdate_____SS#_____

Occupation_____Employer_____Bus. Phone #_____

Whom may we thank for referring you?_____

Physician_____Address_____Phone #_____

Are you in good health?_____ If no, explain_____

Do you have an existing illness?_____If yes, explain_____

Have you been hospitalized in the past two years?_____ If so, please list_____

_____

Do you use tobacco products? _____Yes _____ No If yes, explain type and amount_____

Are you taking any medication, pills or drugs?_____ If so please list_____

_____

Are you allergic to: Penicillin_____ Codeine _____ Anesthetics _____ Aspirin _____ _ Latex _____ Other_____

Do you have frequent, severe headaches?	Yes	No
Do you have a persistent cough with or without blood?	Yes	No
Do you have frequent indigestion?	Yes	No
Do you vomit frequently?	Yes	No
Do you urinate more than six times a day?	Yes	No
Are you thirsty much of the time?	Yes	No
Have you ever had painful and swollen joints?	Yes	No
Do you have a tendency to faint?	Yes	No
Do you bruise easily?	Yes	No

Do you have or have you had any of the following? Please indicate with a check mark.

_____any heart problems	_____aids (HIV)	_____asthma/hay fever
_____rheumatic fever	_____anemia	_____herpes/cold sores
_____abnormal blood pressure	_____diabetes	_____glaucoma
_____nervous problems	_____blood transfusion	_____ kidney problems
_____blood disease	_____heart murmur	_____mitral valve prolapse
_____venereal disease	_____scarlet fever	_____heart surgery (bypass etc..)
_____arthritis	_____radiation treatments	_____circulatory problems
_____epilepsy or seizures	_____stroke	_____TB or Lung disease
_____excessive bleeding	_____hepatitis/jaundice	_____malignancies/cancer
_____ulcers	_____liver disease	_____artificial joint
_____thyroid disease	_____sinus trouble	_____congenital heart lesions

Women: Are you pregnant at the present time?_____If so, what month_____

Name of former dentist_____ Last dental visit_____

Any complications with extractions? Yes _____ No_____

Prolonged bleeding? Yes _____ No_____

Have you ever had a serious problem associated with previous treatment? Yes _____ No_____ If so, explain _____

_____

How often do you brush your teeth?_____ How often do you floss?_____

Do you have difficulty chewing your food or swallowing?	Yes	No
Have you ever had an injury to your face or jaws?	Yes	No
Is it difficult for you to open your mouth as wide as you would like?	Yes	No
Do you clench or grind your jaws while sleeping or during the day?	Yes	No
Do your jaws ever feel tired?	Yes	No
Are your teeth sensitive?	Yes	No
Have you had gum treatments?	Yes	No
Do your gums bleed?	Yes	No
Do you have nasal obstruction?	Yes	No
Any swelling or lumps in your mouth?	Yes	No
Have you had your teeth straightened?	Yes	No
Name of orthodontist	Yes	No

Please describe any medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment:

_____

_____

I have answered the above accurately and completely. I also consent to whatever dental procedures are necessary for the treatment of the above patient and agree to assume full financial responsibility for all treatment rendered.

Signature_____ Date_____

Updates:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

29224 W. EIGHT MILE ROAD
FARMINGTON HILLS, MI 48336
PHONE: 478-1650

Pesis Dental Group

PATIENT'S NAME: _____
(please print)

AUTHORIZATION-RESPONSIBILITY AGREEMENT

I have requested Dr. Solomon and/or Dr. Jacob Pesis D.D.S. to perform needed Dental Services on myself and/or my family. Since I have no dental insurance coverage; I know it is my responsibility to pay for this treatment at the time it is performed.

SIGNED: _____ DATE: _____

I have requested Dr. Solomon and/or Dr. Jacob Pesis D.D.S. to bill my insurance company (for covered services) on my behalf. I know it is my responsibility to make sure that whatever is my portion due, and/or not paid by my insurance company, is paid at the time of service. I hereby authorize my insurance company to pay the proceeds due under my insurance coverage, directly to Dr. Solomon and/or Dr. Jacob Pesis D.D.S.. A copy of this can be considered as an origianl for insurance purposes.

SIGNED: _____ DATE: _____

In order to process a claim for insurance benefits, I authorize Dr. Solomon and/or Dr. Jacob Pesis D.D.S. to release any dental information regarding medical history, symptoms, diagnosis, and treatment. A photocopy of this authorization shall be considered as effective and as valid as the original.

SIGNED: _____ DATE: _____

We must emphasize that as dental care providers, our relationship is with you; not your insurance company! While our filing of the insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are performed.

We at the Pesis Dental Group are committed to providing you with the best possible care! If any questions arise PLEASE don't hesitate to ask us. We are here to help you!