Patient Data

Patient Name ____

Patient Social Security #________________________ Date of Birth ________________

Address ____
Number and street

____
City State Zip

Gender Male ☐ Female ☐ Phone # ___________________________

Email :____

Patient Employer ____

Employer Address ____

Annual Household Income ____

Employment Status ☐ Full-time ☐ Part-time ☐ Unemployed
Student Status ☐ Full-time ☐ Part-time ☐ Not a student
School Completed ☐ Elementary ☐ High School ☐ Some College ☐ College degree
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race (check all that apply)
American Indian or Alaskan Native ☐ Asian ☐ African American/black ☐
Caucasian/White ☐ Native Hawaiian ☐ Other Pacific Islander ☐

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Housing Status ☐ Not Homeless ☐ Transitional ☐ Doubling-Up
☐ Shelter ☐ Street ☐ Other
Language Preference ☐ English ☐ Spanish Other __________________
Is Language Assistance needed? ☐ Yes ☐ No
Are you a Veteran? ☐ Yes ☐ No
Are you a Migrant Worker? ☐ Yes ☐ No
Is anyone in your family a migrant worker? ☐ Yes ☐ No
Is transportation an issue? ☐ Yes ☐ No
Pharmacy Name and Location ____

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Health Information Questionnaire

Name: ____ DOB: _________________

Date of Last Dental Visit:____________________Reason for Visit:__________________________

Have you ever had any of the following health conditions? Please check all that apply.

☐ Allergies____

☐ Anemia	☐ Excessive Bleeding	☐ Jaundice	☐ Respiratory Problems	
☐ Arthritis	☐ Fainting	☐ Kidney Disease	☐ Rheumatic Fever	
☐ Artificial Joints	☐ Glaucoma	☐ Liver Disease	☐ Congenital Heart Defect.	
☐ Asthma	☐ Hay Fever	☐ Mental Disorders	☐ Sexually Trans. Disease	
☐ Blood Disease	☐ Head Injuries	☐ Nervous Disorders	☐ Sinus Problems	
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Stroke Date:_________	
☐ Codeine Allergy	☐ Osteoporosis	☐ Penicillin Allergy	☐ Stomach Problems	
☐ Diabetes	☐ Hepatitis	☐ Pregnancy	☐ Tuberculosis	
☐ Rheumatism	☐ High Blood Pressure	Due Date_______	☐ Tumors	☐ Thyroid Disease
☐ Epilepsy	☐ HIV/AIDS	☐ Radiation Treatment	☐ Ulcers	☐ Heart Surgery
☐ Heart Valve Replacement		☐ Heart Attack		Date:________
☐ Infective Endocarditis		Date:_______		

List all Medications and Dosage ____

____

Have you ever had complications following Dental Treatments? Yes ☐ No ☐

If yes, please explain: ____

Have you been admitted to a hospital or needed emergency care in the past two years? Yes ☐ No ☐

If yes, please explain: ____

Are you now under the care of a physician? Yes ☐ No ☐

If yes, please explain:

Physician Name: Phone Number:

Do you have any health problems that need further clarification? Yes ☐ No ☐

If yes, please explain: ____

Have you ever been told that you need antibiotic medication prior to a dental visit? Yes ☐ No ☐

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient, Parent, or Guardian Date

Provider Intial:______________

Consent for Treatment

Patient Name (Print)____D.O.B.________________

I hereby request and authorize the staff of Family Medical Center of Michigan, USING THE FACILITIES OF Family Medical Center of Michigan, to administer any treatment deemed necessary and advisable for my care until revoked in writing.

Signature ____ Date ____________________

I authorize Family Medical Center of Michigan to release any information necessary to process any medical claims for services provided to myself or family members covered by my insurance policy or required by regulatory or accrediting organizations. I authorize payment of medical benefits be made directly to Family Medical Center of Michigan.	
Signature	Date

I understand that I will receive a statement of my account while my insurance is being billed, until it has been paid in full by my insurance or myself.	Initial

I understand that, if my insurance has not paid a claim within 45 days from the date of service, that I am responsible for contacting my insurance company and/or pay the bill myself.	Initial

I understand that I am responsible for my charges at Family Medical Center of Michigan whether I am self-pay, receiving discounted services, or if my insurance does not pay for the charges incurred at Family Medical Center of Michigan.	Initial

Financial Policy

As a courtesy to our patients, Family Medical Center of Michigan will file your insurance claim with your primary insurance carrier. Family Medical Center of Michigan will supply you, upon request, with all pertinent information to assist in the filing of a claim to your secondary insurance carrier, or we will be glad to file those secondary insurance claims for you on a one-time basis.

To alleviate any misunderstanding regarding insurance payments, all patients must assign their primary insurance company directly to Family Medicla Center. If you want the primary insurance company to pay you directly, Family Medical Center of Michigan will require full payment prior to sevice being rendered. Secondary insurance payments filed by Family Medical Center of Michigan must be assigned directly to Family Medical Center of Michigan. You will be responsible for all balances not covered by your primary or secondary insurance company.

Michigan law requires that insurance companies pay medical practices within a resonable amout of time (45days). If a problem persists, we will ask you to assist us in contacting your insurance carrier. Your insurance converage is a contractual relationship between you and your insurance carrier, not Family Medical Center of Michigan and your insurance carrier (with the execption of managed care patients). Therefore, all claims not paid within a reasonable amout of time (45 days for "clean claims") will become your responsiblility, for which you will receive a bill.

All patients must read and sign Family Medical Center of Michigan's written financial arrangement prior to services being rendered. Our staff will make every effort possible to clairfy any misunderstanding that should occur concerning account balances.

Family Medical Center of Michigan's goal is to create an excellent physician/patient relationship.

Family Medical Center of Michigan uses the following guidelines regarding financial payment:

1. All Patients must read and sign Family Medical Center of Michigan's financial agreement Prior to services being rendered.
2. Insurance payments that have not been received within 60 days after filling will be turned over to the patient's responsibility.
3. The practice, at its sole discreation, may establish weekly/monthly payment arrangements to accommodate individial patient needs.

4. Patients will receive a statement of account each month indicating the amount that is the patients responsibility. Payment of your balance is due within 30days.
5. If you feel that your insruance company has not paid correctly, it is your responsibility to contact them.
6. Patients who do not remit payment in full will be turned over to collection agency. Patients with payment arrangements must comply with their monthly payment plan. Failure to do so will results in turnover to collection agency.
7. Co-Payments are required before services are rendered.
8. If you do not have insurance or have a sliding fee, payment in full is expected at time of service unless you have made prior payment arragements with our patient accounts department.
9. If you have a delinquent account, you will be required to make a payment on your balance in addition to current service before services are rendered.
10. For patients who are eligible for Medicare, we are “participating physicians.” This means that we accept Medicare’s allowed charge for the services rendered, eliminating the difference between what we charge and what Medicare approves. Medicare will send a check directly to our office for 80% of the approved amount. The patient is responsible for 20% of the approved charge, plus any deductible . If you have secondary insurance, we will submit a claim to them once for any remaining balance after Medicare has paid. Please remember that although we will accept assignment for Medicare patients, the beneficiary, as required by federal law, is responsible for 20% of the approved amount and also for any routine services not covered Medicare.
11. In cases of divorce, the parent seeking treatment is ultimately responsible for payment of the bill unless we receive legal documentation stating otherwise.

About Our Notice Of Privacy Practices

Family Medical Center is committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your person health information
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in the Notice
- The person to contact for further informaiton about our privacy practice.

Family Medical Center is required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Name: ___________________________________ D.O.B.__________________

Patient Acknowledgement of Receipt of Policies and Practices

I hereby acknowledge that I have received a copy of Family Medical Center of Michigan's Notice of Privacy Practices.

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Patient Signature Date

____

Parent or Patient Representative Signature Date

____

Description of Legal Authority to act on behalf of Patient

I hereby acknowledge that I have received a copy of Family Medical Center's Financial Policies

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Patient Signature Date

____

Parent or Patient Representative Signature

____

Description of Legal Authority to act on behalf of Patient

Family Medical Center Patient Appointment Responsibility

As a courtesy to our patients, a reminder call is sent out the day before your appointment to remind you of the time and the provider that you will see. In return we are asking our patients to be courteous and to give us a call if you are unable to make your scheduled appointment. Appointment times are very valuable to you, the provider, and to other patients that may be waiting to schedule an appointment.

- In the event that you do not call to cancel or reschedule, you will be considered a No Call No Show (NCNS).
- We will be giving you a call to ask how we can assist you in any way to keep your appointment.
- If three NCNS's occur in a 12 month time period, you will have to wait six (6) months to schedule your next dental appointment.
- Emergency dental needs during the 9-month period in which patients cannot schedule appointments, will be referred to the University of Michigan for services.
- Following the 6-month period in which patients cannot schedule, patients are welcome to contact FMC again to schedule appointments as usual. At this time, the rolling 12-month cycle begins again.

Patient Name: ______________________________ Date: ____________________