



24825 Michigan Ave. • Dearborn, MI 48124 • (313)565-5350

# New Patient Registration

## Personal Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M \_\_\_\_\_  
 Sex \_\_\_\_\_ Citizenship \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Street Address \_\_\_\_\_ Apt# \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_

## Insurance Information

Employer Name \_\_\_\_\_  
 Occupation \_\_\_\_\_ Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Primary Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_ Contract# \_\_\_\_\_  
 Phone# \_\_\_\_\_ Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Secondary Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_ Contract# \_\_\_\_\_  
 Phone# \_\_\_\_\_ Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Guarantor (Responsible Party)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M \_\_\_\_\_  
 Street Address \_\_\_\_\_ Apt# \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Is this person aware you have indicated them as the responsible party?      Yes      No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such Dental Care to third party payers and/or health practitioners. I understand my Dental Insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's (or services not paid by my guarantor if 18 or older as time of services.)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (Patient, legal guardian or authorized agent of patient)



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# Medical History

## Patient Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M \_\_\_\_\_  
 Sex \_\_\_\_\_ Citizenship \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
 Parent or Guardian (if patient is a minor) \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_ Phone# \_\_\_\_\_

## Dental Information

Date of Last Dental Visit \_\_\_\_\_ Date of Last X-rays \_\_\_\_\_  
 Previous Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 What is the purpose of this visit? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Health Questions

	YES	NO		YES	NO
1. May we contact previous dentist for X-ray information?.....			12. Have you ever been told you have mitral valve prolapse?.....		
2. Do you consider yourself to be in good health?.....			13. Women: Are you pregnant?.....		
3. Fair health?.....			If yes, when is your due date? _____		
4. Poor health?.....			14. Do you smoke?.....		
3. Are you now, or have you ever been under a physician's care in the last two years?.....			If yes, please specify type, frequency and amount _____		
If yes, please specify the condition being treated: _____			15. Do you Chew?.....		
4. Are you having any pain or discomfort at this time?.....			If yes, please specify type, frequency and amount _____		
If yes, please describe: _____			16. Do you use alcohol?.....		
5. Do you take any medications, drugs, chemicals or home treatment remedies?.....			If yes, please specify type, frequency and amount _____		
Please specify name and purpose of medications: _____			17. Do you use aspirin?.....		
6. Are you allergic to any local anesthetics?.....			If yes please specify dose size and frequency _____		
7. Do you have any other allergies? If yes, please describe: _____			18. Do you use vitamins or herbal preparations?.....		
8. Do you bleed or bruise easily?.....			If yes, please specify type, frequency and amount _____		
9. Have you ever had heart surgery, a graft to a blood vessel or do you have any artificial joints or organ transplants?.....			19. Do you use birth control pills?.....		
If yes, please describe: _____			20. Are you on a weight control program?.....		
10. Have you ever been told you have a heart murmur?.....			If yes, please specify _____		
11. Have you ever been told you have rheumatic fever?.....			21. Have you ever had a reaction to latex or rubber?.....		
			If yes, please describe: _____		
			22. Do you use "recreational" or "street drugs"?.....		
			If yes, please specify type, frequency and amount _____		
			23. Have you been tested for metal sensitivity?.....		
			If yes, please specify _____		





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## 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.

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### Our Legal Duty

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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 01/06/2003, and will remain in effect until we replace it.

We reserve the right our privacy practices and the terms of this Notice at any time, provided such changed are permitted by applicable law. We reserve the right to make the 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 anytime. 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.

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### Uses and Disclosures Health Information

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We use and disclose health information about you for your 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 the 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 provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any 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 and disclose your 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 our 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 judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.



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## Notice of Privacy Practices Continued

### Uses and Disclosures Health Information (Continued)

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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 authorization.

**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 authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

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

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### Patient Rights

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**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 will charge you \$.90 for each page. \$24.00 per hour 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 you 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 a 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 alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.



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## Notice of Privacy Practices Continued

### Patient Rights (Continued)

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**Amendment:** You 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 Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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### Questions and Complaints

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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 made about access to your health information 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 also may 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 Officer: James Gusfa, D.D.S.

Telephone: (313)565-5350

Fax: (313)565-5561

Email:

Address: 24825 Michigan Ave. Dearborn, MI 48124

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## Acknowledgement of Receipt of Privacy Practices

\*You May Refuse to Sign this Acknowledgement\*

### Patient Use

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 acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual Refused to Sign

Communication barriers prohibited obtaining acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

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# Consent for Use and Disclosure of Health Information

## Section A: Patient Giving Consent

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M \_\_\_\_\_  
 Patient# \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_

## Section B: To the Patient

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**Notice of Privacy Practices:** You have the right to read or Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer: James Gusfa, D.D.S.  
 Telephone: (313)565-5350  
 Fax: (313)565-5561  
 Email:

Address: 24825 Michigan Ave. Dearborn, MI 48124

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

**Signature:**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include a completed consent in the patient's chart



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# Revocation of Consent

## Revocation of Consent

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I revoke my Consent for your use and disclosure of my protected health information activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Financial Policy

### Non-Insured Patients

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Payment is due day of service. Please contact us prior to service if other options are necessary.

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### Insured Patients

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**All estimated co-pays are due day of service.** Some insurance carriers, such as BCBS and DELTA send payment directly to the patient. In this case your payment will be due on service date and your reimbursement will be sent to you by your insurance company.

If your insurance does not pay what we originally expected, the remaining balance will be due within 30 days.

Please understand your insurance coverage is a contract between you, your employer and your insurance company. We will assist in any way we can to answer question regarding coverage, but ultimately it is your responsibility to understand your insurance plan. Our office verifies benefits as a courtesy to you.

When our office submits pre-authorizations or calls to verify coverage, the responses received are estimates of coverage. Final payment and determination of benefits cannot be made until the final claim is submitted and reviewed by your carrier once services are completed.

Patients having **dual insurance** coverage should be aware that it does not guarantee 100% coverage. You are responsible for any fees not covered by your carriers. Some plans have a non-duplication of benefits clause. With dual insurance claims involving BCBS or DELTA please check with our business office for more information.

**We accept:** Check, Cash, Mastercard, Visa, Discover, or Care Credit

In the event that children of divorced parents are treated in our office, the parent present with the child is responsible for the co-pay or fee for services rendered. We cannot bill the other parent.

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