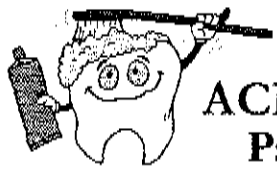


ACE DENTAL CARE, PLLC
Patient Registration

Patient Name_____ Date of Birth_____ Sex___M ___F

Address_____ City_____ State_____ Zip_____

Home_(__)_____ Work_(__)_____ Cell_(__)_____

Email_____ SS#_____

Single_____ Married_____ Divorced_____ Widowed_____

Patient Employer_____ Employer Phone #_____

RESPONSIBLE PARTY IF PATIENT IS A MINOR

Parent/Guardian
Name_____ Relationship_____

Address_____ City_____ State_____ Zip_____

Home_(__)_____ Work_(__)_____ SS#_____

INSURANCE INFORMATION

Primary	**Secondary**
Subscriber_____	Subscriber_____
Birthdate_____	Birthdate_____
SS#_____	SS#_____
Employer_____	Employer_____
Employer Phone_____	Employer Phone_____
Dental Ins. Co._____	Dental Ins. Co._____
Group/Policy #_____	Group/Policy #_____

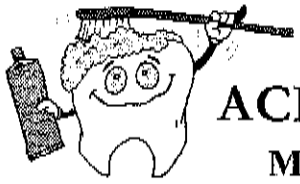
Whom may we thank for referring you?_____

In case of emergency:
Name_____ Phone #_____ Relationship_____

Authorization, Release and Agreement

I authorize payment of all insurance benefits directly to Ace Dental Care, PLLC. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me to my insurance company so that a claim for reimbursement can be filed on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of patient or guardian_____ Date



ACE DENTAL CARE, PLLC

MEDICAL HISTORY

Patient Name_____ **Date**_____

Physician's Name_____ Phone #_____

Do you have or have you had any of the following conditions:

- ☐ AIDS/ HIV Positive
- ☐ Arthritis, Rheumatism
- ☐ Alzheimer's Disease
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Pins, Rods or Plates
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Problems
- ☐ Cortisone Treatments
- ☐ Cough (Persistent or Bloody)
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Describe_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ A___B___C____
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Problems/Jaundice
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Sleep Apnea/Snoring
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Bone Sparing/Bisphosphonate Drugs

Are you currently taking or have you taken any medication meant to treat osteoporosis, bone cancer or Paget's disease? Yes_____ No_____

If yes, do you take the oral form (pill)_____ or IV_____

How long have you been on the medication_____

Date of last dose of the medication_____

Name of the bone sparing medicine (such as Actonel, Boniva, Fosamax, Aredia, Zometa, Reclast)_____

Medications

List any medications you are currently taking:

_____

_____

Pharmacy Name_____

Pharmacy Phone #_____

Women

Are you pregnant? Yes_____ No_____
Are you trying to become pregnant? Yes_____ No_____
Are you taking oral contraceptives? Yes_____ No_____
Are you nursing? Yes_____ No_____

Allergies

Aspirin	Local Anesthetics
Codeine	Penicillin
Iodine	Sulfa
Latex	Other_____

DENTAL HISTORY

Reason for today's visit_____ Date of last dental visit_____ Last dental cleaning_____ Last full mouth xrays_____

Are you happy the the appearance of your teeth? (color, shape, size)	Yes_____ No_____
Are your teeth temperature sensitive? (hot or cold)	Yes_____ No_____
Are your teeth sensitive while biting or chewing?	Yes_____ No_____
Do you frequently get cold sores or canker sores?	Yes_____ No_____
Have you ever had orthodontic treatment?	Yes_____ No_____
How often do you brush your teeth?_____	
How often do you floss your teeth?_____	
Do you use an "electric" toothbrush?	Yes_____ No_____
Does food become stuck between certain teeth?	Yes_____ No_____
Do your gums bleed when you brush?	Yes_____ No_____
Have you ever had periodontal treatment?	Yes_____ No_____
Do you clench or grind your teeth?	Yes_____ No_____
Do you frequently wake up with a headache?	Yes_____ No_____
Do you have clicking, popping or discomfort in the jaw joint?	Yes_____ No_____
Do you have a bite guard?	Yes_____ No_____
Do you have a dry mouth?	Yes_____ No_____
Do you feel that you have bad breath?	Yes_____ No_____
Would you like to keep your teeth the rest of your life?	Yes_____ No_____

Please add anything else about your dental history that you would like us to know._____

UPDATES (to be filled in at future appointments)

Has there been any changes in your health since your last appointment Yes_____No_____
For what condition?_____
Are you taking any new medications?_____If so, what?_____
Patient's Signature_____
Doctor's Signature_____

Has there been any changes in your health since your last appointment Yes_____No_____
For what condition?_____
Are you taking any new medications?_____If so, what?_____
Patient's Signature_____
Doctor's Signature_____

ACE DENTAL CARE, PLLC

Dr. William R. Monks
Dr. Rose Ann J. Bartnik

47100 Schoenherr, Suite A
Shelby Twp., MI 48315

586-566-TEETH
(8338)

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 ____/____/____, 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 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 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 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 to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation 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.

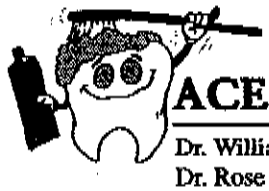
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, 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 judgment 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 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.



ACE DENTAL CARE, PLLC

Dr. William R. Monks
Dr. Rose Ann J. Bartnik

47100 Schoenherr, Suite A
Shelby Twp., MI 48315

586-566-TEETH
(8338)

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

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)

_____

_____

_____

ACE
DENTAL CARE, PLLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 our 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 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 Person: *Dr. Bartnik - Ace Dental Care PLLC*

Telephone: *586.566.8338* Fax: *586.566.8339*

E-mail: *acedentalcare@gmail.com*

Address: *47100 Schoenherr, Ste A - Shelby Township, MI 48315*

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 to 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 to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

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

Personal representative's Name: _____

Relationship to Patient: _____

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

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment 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: _____