



W E L C O M E

In order to ensure your maximum oral health and allow us to prescribe the proper medications, it is very important that we know all medical and dental information about you. Please complete every box on this form, even if the answer is "N/A" (not applicable). This information will be kept in the strictest confidence.

You also should know that changes in other parts of your body may affect the oral cavity and what dental treatment can be done, even if they seem unconnected. Cardiac (heart) problems, artificial joints and diabetes are just some examples.

Will you please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions have changed since we last saw you? Yes ___ No ___ . Thank You.

1. Patient Information

Date _____

NAME _____
LAST FIRST MI

Address _____

City State Zip

I prefer to be called: _____ TITLE _____
MR MRS MS DR

Birth date _____ Gender: F ___ M ___ Age _____

___ Single ___ Married ___ Widowed ___ Separated ___ Divorced

Patient SS# _____

Patient Drivers License# _____

If patient is a minor, give parent's or guardian's name: _____

Occupation _____

Employer _____

Spouse's Name _____

Spouse's Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance (Primary)

Who is responsible for this account? _____

SS# _____ Birthdate _____

Relationship to Patient: _____

Insurance Co. _____

Group # _____

Relationship to Minor (if applicable)

Date

3 Phone Numbers

Home Phone _____

Work _____ Ext _____

CELL _____ PAGER _____

Spouse's Work _____

Spouse's work: _____

Spouse's cell: _____

e-mail address _____

IN CASE OF EMERGENCY, CONTACT
(Specify someone who does not live in your household.)

Name _____

Relationship _____

Home Phone _____

Work Phone _____

Family Physician's Name _____

Physician's Phone# _____

Is Patient covered by another insurance plan Y ___ N ___

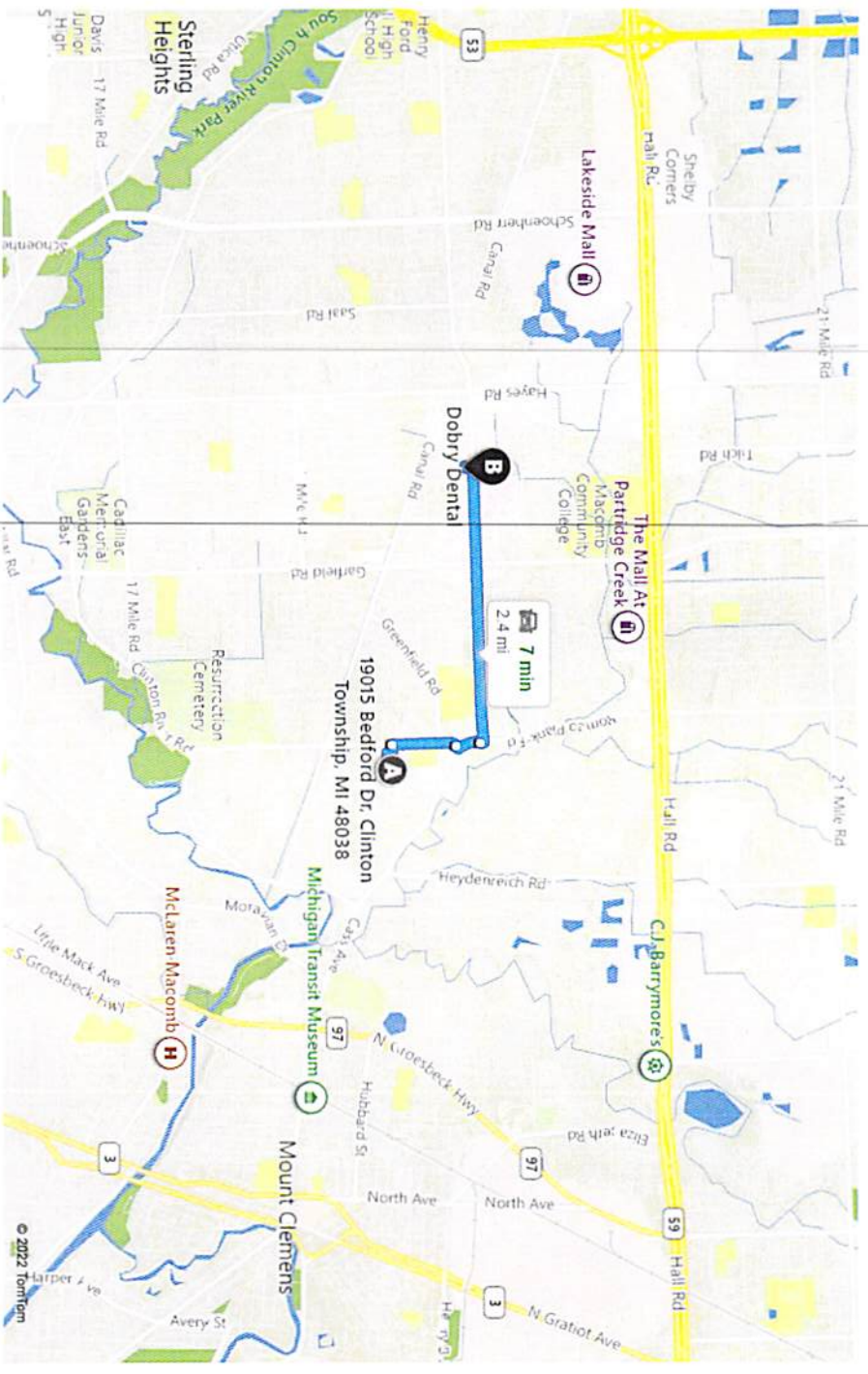
Secondary Dental Insurance

Subscriber name _____

SS# _____ Birth date _____

Insurance CO _____

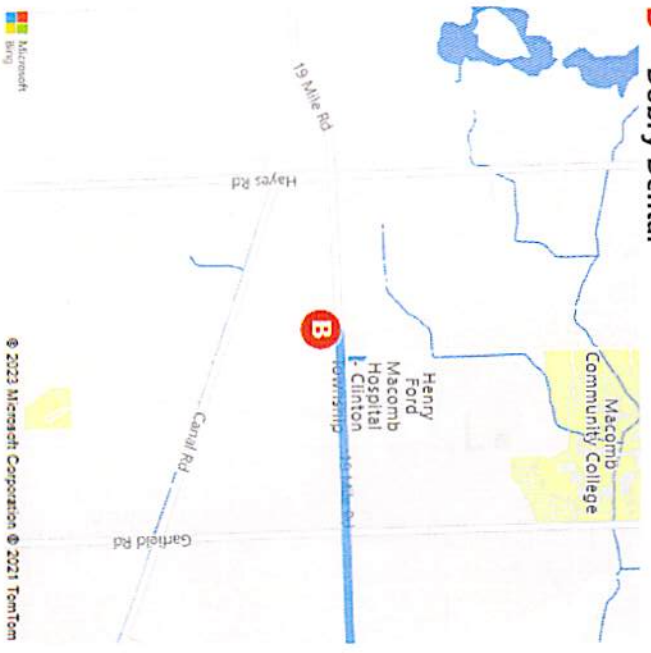
Group# _____



A 19015 Bedford Dr, Clinton Township, MI 4...



B Dobry Dental



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Patient Name _____

MEDICAL HISTORY

Patient Account No. _____

Medical Alert _____

1. Physician's Name _____ Phone () _____
Have you had any medical care within the past two years? Yes ☐ No ☐
Describe _____
2. Have you taken any medication or drugs during the past two years? Yes ☐ No ☐
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Yes ☐ No ☐
If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes ☐ No ☐
If yes, did you take any of the following? (circle if yes) Fen-Phen ☐ Pondimin ☐ Redux ☐ Other ☐
If yes to any of the above, did you have a medical exam for heart issues? Yes ☐ No ☐
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? Yes ☐ No ☐
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes ☐ No ☐
If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? Yes ☐ No ☐
8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.
- | | | | | | |
|---|--|-------------------------------|--|----------------------------------|--|
| Heart (Surgery, Disease, Attack) ... | Yes <input type="radio"/> No <input type="radio"/> | Ulcers | Yes <input type="radio"/> No <input type="radio"/> | Hepatitis A B C (circle) ... | Yes <input type="radio"/> No <input type="radio"/> |
| Chest Pain | Yes <input type="radio"/> No <input type="radio"/> | Diabetes | Yes <input type="radio"/> No <input type="radio"/> | Venereal Disease | Yes <input type="radio"/> No <input type="radio"/> |
| Congenital Heart Disease | Yes <input type="radio"/> No <input type="radio"/> | Thyroid Problems | Yes <input type="radio"/> No <input type="radio"/> | A.I.D.S./H.I.V. Positive | Yes <input type="radio"/> No <input type="radio"/> |
| Heart Murmur | Yes <input type="radio"/> No <input type="radio"/> | Glaucoma | Yes <input type="radio"/> No <input type="radio"/> | Cold Sores/Fever Blisters | Yes <input type="radio"/> No <input type="radio"/> |
| High/Low Blood Pressure | Yes <input type="radio"/> No <input type="radio"/> | Contact lenses | Yes <input type="radio"/> No <input type="radio"/> | Blood Transfusion | Yes <input type="radio"/> No <input type="radio"/> |
| Mitral Valve Prolapse | Yes <input type="radio"/> No <input type="radio"/> | Emphysema | Yes <input type="radio"/> No <input type="radio"/> | Hemophilia | Yes <input type="radio"/> No <input type="radio"/> |
| Artificial Heart Valve/Pacemaker | Yes <input type="radio"/> No <input type="radio"/> | Chronic Cough | Yes <input type="radio"/> No <input type="radio"/> | Sickle Cell Disease | Yes <input type="radio"/> No <input type="radio"/> |
| Rheumatic Fever | Yes <input type="radio"/> No <input type="radio"/> | Tuberculosis | Yes <input type="radio"/> No <input type="radio"/> | Bruise Easily | Yes <input type="radio"/> No <input type="radio"/> |
| Arthritis/Rheumatism | Yes <input type="radio"/> No <input type="radio"/> | Asthma | Yes <input type="radio"/> No <input type="radio"/> | Liver Disease/Yellow Jaundice .. | Yes <input type="radio"/> No <input type="radio"/> |
| Cortisone Medicine | Yes <input type="radio"/> No <input type="radio"/> | Hay Fever/Allergy/Hives | Yes <input type="radio"/> No <input type="radio"/> | Neurological Disorders | Yes <input type="radio"/> No <input type="radio"/> |
| Swollen Ankles | Yes <input type="radio"/> No <input type="radio"/> | Latex Sensitivity | Yes <input type="radio"/> No <input type="radio"/> | Epilepsy or Seizures | Yes <input type="radio"/> No <input type="radio"/> |
| Stroke | Yes <input type="radio"/> No <input type="radio"/> | Sinus Trouble | Yes <input type="radio"/> No <input type="radio"/> | Fainting or Dizzy Spells | Yes <input type="radio"/> No <input type="radio"/> |
| Diet (Special/Restricted) | Yes <input type="radio"/> No <input type="radio"/> | Radiation Therapy | Yes <input type="radio"/> No <input type="radio"/> | Nervous/Anxious | Yes <input type="radio"/> No <input type="radio"/> |
| Artificial Joints (hip, knee, etc.) ... | Yes <input type="radio"/> No <input type="radio"/> | Chemotherapy | Yes <input type="radio"/> No <input type="radio"/> | Psychiatric/Psychological Care.. | Yes <input type="radio"/> No <input type="radio"/> |
| Kidney Trouble | Yes <input type="radio"/> No <input type="radio"/> | Tumors | Yes <input type="radio"/> No <input type="radio"/> | | |
9. Have you lost or gained more than 10 pounds in the past year? Yes ☐ No ☐
10. Do you have or have you had any disease, condition, or problem not listed? Yes ☐ No ☐
if yes, please list: _____
11. Women: Are you pregnant or think you could be pregnant? Yes ☐ Months _____ No ☐ Nursing? Yes ☐ No ☐
12. Do you use birth control prescriptions? Yes ☐ No ☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____

Date _____

History Review

Submit by Email

Print Form

Dentist Signature _____

Date _____

Patient Name _____

Submit by Email

Print Form

DENTAL HISTORY

Patient Account No. _____

Medical Alert _____

*Welcome! So that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.*

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

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

Have you ever used or are currently using topical fluoride? Yes ☐ No ☐

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes ☐ No ☐

If yes, please describe: _____

Are any of your teeth sensitive to:Hot or cold? Yes ☐ No ☐Sweets? Yes ☐ No ☐Biting or Chewing? Yes ☐ No ☐Have you noticed any mouth odors or bad tastes? Yes ☐ No ☐Do you frequently get cold sores, blisters or
any other oral lesions? Yes ☐ No ☐Do your gums bleed or hurt? Yes ☐ No ☐Have your parents experienced gum disease
or tooth loss? Yes ☐ No ☐Have you noticed any loose teeth or change
in your bite? Yes ☐ No ☐Does food tend to become caught in between
your teeth? Yes ☐ No ☐

If yes, where? _____

Do you:Clench or grind your teeth while awake or asleep? Yes ☐ No ☐Bite your lips or cheeks regularly? Yes ☐ No ☐Hold foreign objects with your teeth?
(pencils, pipe, pins, nails, fingernails) Yes ☐ No ☐Mouth breathe while awake or asleep? Yes ☐ No ☐Have tired jaws, especially in the morning? Yes ☐ No ☐Snore or have any other sleeping disorders? Yes ☐ No ☐Smoke/chew tobacco or use other tobacco products? Yes ☐ No ☐**Have you ever had:**Orthodontic treatment? Yes ☐ No ☐Oral Surgery? Yes ☐ No ☐Periodontal treatment? Yes ☐ No ☐Your teeth ground or the bite adjusted? Yes ☐ No ☐A bite plate or mouth guard? Yes ☐ No ☐A serious injury to the mouth or head? Yes ☐ No ☐

If so, please describe, including cause _____

Have you experienced:Clicking or popping of the jaw? Yes ☐ No ☐Pain? (joint, ear, side of face) Yes ☐ No ☐Difficulty in opening or closing the mouth? Yes ☐ No ☐Difficulty in chewing on either side of the mouth? Yes ☐ No ☐Headaches, neckaches or shoulder aches? Yes ☐ No ☐Sore muscles (neck, shoulders)? Yes ☐ No ☐**Are you satisfied with your teeth's appearance?** Yes ☐ No ☐Would you like to keep all of your teeth all of your life? Yes ☐ No ☐Do you feel nervous about having dental treatment? Yes ☐ No ☐

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes ☐ No ☐

If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes ☐ No ☐Is there anything else about having dental treatment that you would like us to know? Yes ☐ No ☐

If yes, please describe _____

(Please complete other side)



DOBRY
DENTAL

John A. Dobry, DDS

15870 19 Mile Road, Suite 160 ♦ Clinton Township, MI 48038 ♦ (586) 286-0790

Financial Policy

Our office strives to provide the highest quality dental care at affordable prices. Our patients receive prompt attention and excellent service. We believe that a satisfied patient returns for additional services, refers others to the practice and pays their bill promptly. To help maintain a good relationship with our patients, this office has adopted a written financial policy. The purpose of this policy is to eliminate confusion or misunderstanding concerning financial arrangements offered by our office. Our office communicates this policy to each patient.

For those with insurance benefits, we are happy to bill your insurance as a courtesy to you. Please note that your insurance contract exists solely between you and your insurance carrier. We will file your insurance claim, but we cannot guarantee any benefits. Your insurance plan is a benefit to you to help offset the cost of necessary dental care. Ultimately, you are responsible for the entire cost of your dental therapies. Any questions or comments regarding your benefits should be directed to your insurance carrier.

1. Payment at the time of service is expected, including the estimated portion of the amount that insurance does not cover. Our office accepts the following payment methods: Cash, Check, MasterCard and VISA.
2. When the patient's portion cannot be paid at the time of service and payment arrangements extend beyond 12 months, an interest rate of 9% per annum will be charged on all outstanding balances.
3. A credit report will be generated on each new patient that is offered payment arrangements. A credit report may also be generated on established patients, prior to extending payment arrangements. Payment history with our office will be taken into consideration when establishing payment arrangements.
4. Interest of 9% per annum will be assessed on the patient's portion of the unpaid balance as noted above (#2). A written, signed agreement will be completed at our office, which explains the number of payments, interest rate and total interest to be paid over the term of the agreement.
5. A statement for services rendered will be mailed to you at the end of each month. Receipt of payment is expected by the 10th of the month. The patient's payment should be mailed with the top portion of the statement to establish the proper crediting of the account.
6. Your account due is considered delinquent if the requested payment is not received by the tenth (10th) of the month. If payment is not received, a late charge of ¼% per month (\$1.00 minimum) will be assessed and will appear on the next statement. The annual percentage rate is 9%.
7. A \$20.00 charge will be billed to your account for any check returned by the bank for any reason. We will resubmit the check for payment to the bank one time. However, if funds are still insufficient, we will not accept payments by check from you in the future.
8. There will be no charge for a broken appointment with 24 hours' notice. This enables us to fill the reserved time slot from our list of patients who are able to come on short notice. Broken appointments with less than 24 hours' notice will incur a \$20.00 fee.
9. Delinquent accounts may be sent to a collection agency.
☐ Yes, I am interested in payment arrangements that may be made available to me in order to complete my dental treatment.

I have read and understand the financial policy of Dr. Dobry and agree to all the terms described in it.

Patient Signature/Guardian Signature

Date



DOBRY
DENTAL

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586-286-0790
Fax: 586-286-3682
dr.dobry58@gmail.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____

Patient number _____

Patient address _____

Patient phone number _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about dental health services] under the following terms and conditions. The person you can authorize my information are:

pt) _____ Date _____ (Relationship to
(Name or person)

pt) _____ Date _____ (Relationship to