Welcome to Saigh Family Dental

528 N. 1st Street • Iron River, MI 49935
(906) 265 0050 • (906) 265 0069 fax

Saigh Family Dental
Personalized & Comfortable

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ (Last Name / First Name / Initial) Home Phone _____

Address _____ Cell Phone _____

City _____ E-mail _____

Sex ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1) Are you currently under medical treatment?	☐	☐
2) Have you ever had any serious illnesses or operations?	☐	☐
3) Are you currently taking any medication?	☐	☐

Please describe: _____

_____

_____

4) Do you smoke?	☐	☐
5) Do you use alcohol, cocaine or other drugs?	☐	☐
6) Do you wear contact lenses?	☐	☐

7) Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8) (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis - Type____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Other ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

SAIGH FAMILY DENTAL
Dr. FM Saigh III
528 North 1st Ave.
Iron River, MI 49935
(906) 265-0050

NOTICE OF PRIVACY PRACTICES

THIS NOTICE BELOW DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION.
PLEASE READ THIS INFORMATION CAREFULLY

Uses and Disclosures:

Treatment:
Your health information may be used by staff members and/or disclosed to other health care professionals for the purpose of diagnosing your condition and providing your treatment. For example, your radiological and laboratory results will be made available to consulting health professionals for continuity of care.

Payment:
Your health information may be used to procure payment from your health plan, workmen's compensation, and automobile carrier in the event of a motor vehicle accident. We may also ask for credit card information to put through a charge at your request. An example of a situation requiring the exchange of health information would be providing supporting medical documentation when needed to support medical necessity of a test, procedure, or prescription. Occasionally your insurance company will need proof of necessity. This exchange of information may be crucial in receiving payment from your insurance company.

Health Care Operations:
Your health information may be used as necessary at Saigh Family Dental. In daily operations, financial reporting and quality control. An example of this is appointment reminders.

Law Enforcement and Public Health:
Your health information may be disclosed without your permission when subject to government audit and law enforcement investigations. We must also disclose to public health agencies as required by law. Example, communicable disease reporting.

Other Disclosures:
Disclosure of your health information other than listed above will require your specific written authorization; however this will not affect the release of personal information that occurred prior to the revocation

YOUR INDIVIDUAL RIGHTS:

- You have the right to restrict the disclosures of your private health information.
- You may obtain a copy of our private practices.
- You have the right to know who has requested and/or received your dental records.
- As permitted by federal regulation you may submit a written request to review your record.
- You may submit a comment, concern, or written complaint about our privacy policies and practices.

PRACTICE RIGHTS AND DUTIES:

- As permitted by law we may amend/modify our privacy policies and practices.
- These changes may be required to comply with federal and state laws. Practice revisions will be provided to you at your next office visit.

SIGNATURE:

I have reviewed this consent form and given my permission to Saigh Family Dental to use and disclose my dental information in accordance with it.

_____

Printed Name of Patient

_____

Signature of Patient Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient

Saigh Family Dental

F.M. Saigh, DDS

528 N. 1st Ave. Iron River, MI 49935
Phone 906-265-0050 Fax 906-265-0069

FINANCIAL POLICY

We are committed to providing you with the best possible dental care at the lowest possible cost. We do our best to ensure that the maximum allowable benefits are received for claims filed. In order to achieve these goals, we need your assistance in maintaining accurate information and your understanding of our payment policy.

Payment for an office visit is due at the time service is rendered. We do not accept a medical card for any services.

A charge of $35 will be assessed for returned checks. Also, $50 will be assessed for "no show" appointments. A minimum of 24 hours notice is expected for cancelled appointments. Your appointment is a reserved time with the Doctor or our Hygienist and that time is very valuable and affects many other patients who are scheduled.

You must realize that:

> Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
>
> We review our fees periodically to ensure that our charges are within the usual, customary, and reasonable range for this region, within our specialty of practice. Many insurance companies reimburse based on ***their*** arbitrary schedule of fees, which bears no relationship to the current standard and cost of dental care in this area. Furthermore, the insurance company's arbitrary schedule of fees ***does not reflect this office's standard for using the highest quality dental materials and equipment***.
>
> Not all services are a covered benefit in all contracts. Most insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. While filing of insurance claims is ***a courtesy*** that we extend with certain insurance companies, ***all charges are your responsibility*** from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, you are encouraged to contact us promptly for assistance in the management of your account.

Please ask if you have any questions. We are here to help you.

I have read and understand this policy.

Patient Signature **Date**

Saigh Family Dental

INSURANCE AUTHORIZATION
NOTICE OF PRIVACY PRACTICE POLICY

Dr. Frederick M. Saigh III
528 N. 1st Ave.
Iron River, MI 49935
(906)265-0050

SIGNATURE ON FILE

__ **I authorize use of this form on all my insurance submissions.**

__ **I authorize release of information to all my insurance carriers.**

__ **I understand that I am responsible for my bill.**

__ **I authorize Saigh Family Dental to act as my agent in obtaining information to my insurance carrier.**

__ **I authorize payment to Saigh Family Dental.**

__ **I permit a copy of this authorization to be used in place of the original.**

__ **I acknowledge that the Saigh Family Dental Notice of Privacy Practices was made available to me.**

Name: _____

Signature: _____ **Date:** _____

Saigh Family Dental
FREDERICK M. SAIGH III, D.D.S.

PATIENT CONSENT TO RELEASE DENTAL INFORMATION

_____ At this time, I **DO NOT** wish to share my dental records with anyone.

I _____ authorize Saigh Family Dental of Iron River, MI to release any dental information, when requested by the following people, without having my written consent on an individual basis:

THIS DOES NOT APPLY TO OTHER DOCTORS.

THIS DOES NOT APPLY TO PSYCHIATRIC RECORDS.

NAME	PHONE NUMBER

This consent is valid for 12 months from the date it is signed.

_____ _____

Signature Date