Timothy P. Thomas, DDS, PC

You only get one first impression...How's your smile?

Dear Patient,

We would like to extend a very warm welcome to our office and thank you for selecting us to care for your dental health.

It is our purpose to provide each patient with the highest quality of dental care in a gentle, efficient, and pleasant atmosphere. Our office is designed from the reception area to the care area with your family in mind. We want our patients to grow up with healthy teeth, attractive smiles, and a positive attitude toward dentistry. Our office staff and preventive philosophy will help achieve these goals for your family.

Enclosed you will find beneficial information as well as several forms to complete, including a health questionnaire, the Patient Acknowledgement and Consent (HIPPA Privacy Act), the Release of Dental Information, and the Antibiotic Premedication Protocol forms. Please complete all forms with the pertinent information and signatures. These forms are required for federal compliance and the American Dental Association recommendations for all patients.

Prior to your first visit to our office, we would like to have the names and phone numbers of previous dental providers (i.e. general practitioners, endodontists, oral surgeons, periodontists, and temporomandibular joint specialists) so that we may obtain any prior records, especially recent radiographs (within 2 years), so that we may better service your needs.

Generally, on your first visit, your medical and dental health will be assessed. You will be given a thorough professional oral examination and necessary x-rays will be taken for diagnosis, followed by a consultation of your dental needs. If you have an emergency dental problem requiring immediate attention, it will be taken care of initially. We will also take the time to discuss treatment plans, their significance, and costs, and financial arrangements will be made prior to servicing your dental needs.

An estimate for the comprehensive professional exam and radiographs is $~~165~~ 185 to $240 285 without dental benefits.

Again, we welcome you to our practice. If we can help you in any way, please give us a call at your convenience. Our team is looking forward to meeting you.

Sincerely,

Timothy P. Thomas, DDS

Timothy P. Thomas, DDS
TPT/mk

37799 Professional Center Drive, Suite 101 • Livonia, MI 48154 • (734) 464-2664
Email: info@timothythomasdds.com • www.mylivoniasmiles.com

Patient Number ____________ A B C **HEALTH HISTORY & REGISTRATION**

PATIENT INFORMATION

PATIENT'S NAME Last ________ First ________ Middle Initial ____ SEX M F BIRTHDATE ________ AGE ____

Soc. Sec. # ________ If Patient is a Minor, give Parent's or Guardian's Name ________ TODAY'S DATE ________

Who May We Thank for Referring You to our Office? ________ Reason for this Visit ________

RESPONSIBLE PARTY INFORMATION

NAME Last ________ First ________ Middle Initial ____ MARITAL STATUS ________

RESIDENCE Street ________ Apt. # ____ City ________ State ____ Zip ________

MAILING ADDRESS Street ________ Apt. # ____ City ________ State ____ Zip ________

HOW LONG AT THIS ADDRESS ________ HOME PHONE ________ CELL PHONE ________

WORK PHONE ________ E-MAIL ________

PREVIOUS ADDRESS (if less than 3 yrs.) Street ________ City ________ State ____ Zip ____ How Long ____

SOCIAL SECURITY # ________ BIRTHDATE ________ DRIVER'S LICENSE # ________ RELATION TO PATIENT ________

EMPLOYER ________ OCCUPATION ________ NO. YEARS EMPLOYED ________

RESPONSIBLE PARTY'S SPOUSE

NAME ________ (LAST / FIRST / MIDDLE)

EMPLOYER ________ OCCUPATION ________ ( ) NO. YEARS EMPLOYED

SOC. SEC. # ________ BIRTHDATE ________

HOME PH. ________ CELL PH. ________

WORK PH. ________ E-MAIL ________

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME ________ RELATIONSHIP ________

ADDRESS ________ CITY, STATE ________

HOME PH. ________ CELL PH. ________

WORK PH. ________

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ________

Insurance Co. ________ E-MAIL ________

Insurance Co. Address ________

Insured's Employer ________

Insured's Soc. Sec. # ________ Group # ____ Local # ____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name ________

Insurance Co. ________ E-MAIL ________

Insurance Co. Address ________

Insured's Employer ________

Insured's Soc. Sec. # ________ Group # ____ Local # ____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist:

City: State:

How do you feel abo u your teeth?

Please RANK the followin g in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # ____ LACK of concern # ____

COST of treatment # ____ MISSING work time # ____

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	■

PLEASE ✔ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Condition	YES	NO	Condition	YES	NO	Condition	YES	NO
AIDS/HIV Pos.	☐	☐	Fainting	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Food allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial heart valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐				Shortness of breath	☐	☐
Atopic (Allergy Prone)	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Skin rash	☐	☐
Back problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Kidney disease or malfunction	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Material allergies (latex, wool, metal, chemicals)	☐	☐	Tonsillitis	☐	☐
Cough (persistent)	☐	☐				Tuberculosis	☐	☐
Cough up blood	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Epilepsy	☐	☐	Pacemaker/heart surgery	☐	☐			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin · Local Anesthetic · Erythromycin · Latex (balloons, gloves, etc.)
Nitrous Oxide · Codeine · Penicillin

Are you aware of being allergic to any other medications or substances?
If yes, please list:

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN ________ PHONE ________ E-MAIL ________

PATIENT Signature (Parent of Child) ________ Date: ________ DENTIST Signature ________

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Timothy P Thomas DDS, P C
37799 Professional Center Dr Ste 101 Livonia MI 48154 734-464-2664
Fax 734-464-4778
Email: info@timothythomasdds.com

"HIPAA" Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosure of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

_______________________ _______________________

Patient Signature **Patient Name (please print)**

Date _______________________

For office use only. Patient refused to sign
The following circumstances prohibited the patient from signing the Acknowledgement:

____

Office personnel (signature) **Office personnel (print name)**

Date: _______________________

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_______________________ _______________________

Patient Signature **Patient Name (please print)**

Date: _______________________

Timothy P. Thomas, DDS, PC

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Authorization for Release of Dental Information

I, __________ ___________, authorize ______________________________ and staff to release the following dental information to Timothy P. Thomas, DDS, and staff.

(Please initial appropriate line)

______ Any and all of my dental records (as of the date of this release and 2 years prior if applicable)

______ Any and all of my dental records **except** the following:

____

This release authorizes the transfer of a duplicate set of records accrued within the previous two years. This release specifically allows the release of the following information (this information **will not** be released unless the appropriate line is initialed):

_____ Any record of treatment for Drug and/or Alcohol dependency or abuse

_____ Any record of Mental Health Treatment

_____ Any record of testing, care, treatment, reporting, or research pertaining to infection with HIV or related diseases

Transfer to: Timothy P. Thomas, DDS
37799 Professional Center Drive, Suite 101
Livonia, MI 48154
734-464-2664
info@timothythomasdds.com

Name of Patients to be transferred:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

S/______________________________ Date ______________________
Patient/Legal Guardian of Patient

S/______________________________
Witness

Timothy P. Thomas, DDS, PC

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INSURANCE CLAIMS PROCESS

Our office is pleased that you have insurance benefits to help you with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so that we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

As a courtesy, we file private care insurance (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. WE ESTIMATE YOUR PORTION BASED ON THE MOST UP-TO-DATE INFORMATION WE HAVE, BUT IT IS ONLY AN ESTIMATE ON A NON-PAR STATUS.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL. WHY?

We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to visiting our office, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so that we may adjust accordingly.

INSURANCE DIDN'T PAY. NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS

Our office does request payment in full for your estimated portion at the time of service. All accounts not paid in full after 60 days will be charged a finance charge at a rate of 2% per month (24% per annum). If you are in need of an extended option, please just ask one of the patient services staff for an application.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at your office, Timothy P. Thomas, DDS, PC.

Name:______________________________________ Date:____________________

Timothy P. Thomas, DDS, PC

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FINANCIAL MENU

We consider our relationship with you to be of primary importance and will always make our recommendations based on what we believe is the very best treatment for you, regardless of your insurance coverage or financial arrangements. For your comfort and convenience, we offer a wide range of financial options and welcome your suggestions and questions.

A) Prepayment in Full (For treatment over $400)

A prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit. (cash/check only)

B) Pre-Authorized Credit Card Agreement

With your permission and signature, we will charge your Visa, MasterCard, American Express, or Discover with an agreed payment amount each month. This allows you to make monthly payments without applying for additional credit.

C) Split Payment

1/3 of the total treatment is due at the preparation visit, the second 1/3 is due the day of cementation of the crowns/bridges/veneers, and the final 1/3 on the 15th of the following month.

D) Pay as You Go

You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

E) CareCredit Plan

With fast approval over the phone from CareCredit, your payment can be much lower than those available through our office. CareCredit specializes exclusively in helping patients with larger dental cases to receive the treatment they want. CareCredit carries fixed rates and can extend terms out to 60 months. There is no prepayment penalty. We will assist you in contacting them from our office.

F) Gradual Treatment Plan

FOR THOSE PATIENTS ON A LIMITED BUDGET. By prioritizing treatment, those patients who do not have dental insurance or are on a tight budget can still complete their dental work by spreading appointments over several months or years. This plan has interest that applies each month.

G) Senior Discount

Seniors 65 years young receive a 10% senior discount on payment of patient responsibility.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Money Order, Personal Checks, or CareCredit Plan (see above).

I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect on this account.

I certify that I have read, fully understand, and accept the above financial policy.

Signature:______________________________ Date:______________________

37799 Professional Center Drive, Suite 101 • Livonia, MI 48154 • (734) 464-2664

Email: info@timothythomasdds.com • www.mylivoniasmiles.com

Timothy P. Thomas, DDS, PC

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APPOINTMENT AGREEMENT

At Timothy P. Thomas, DDS, PC, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 hours, you will be subject to a $50 late cancellation charge.

We truly appreciate your understanding. Our goal at Timothy P. Thomas, DDS, PC is to be your partner in health and to assist you in keeping your teeth for a lifetime.

By signing below, I agree to fulfill my obligation as a patient at Timothy P. Thomas, DDS, PC and agree to the "broken appointment" fee should I not give proper notification.

____ ____________________

Signature of patient or responsible party Date