Clinton Dental Center
Roman R. Sadikoff, D.D.S.

Date: ____/____/____

Child and Legal Dependant Patient Information

Patient Name: _____ **Date of Birth:** ____/____/____
First Name MI Last Name Month Day Year

Address: _____
House Number Street Apt. # City State Zip

Residence Phone #: _____ ☐ Male ☐ Female
Area code Number

Child Lives With: ☐ Both Biological Parents ☐ Mom ☐ Dad ☐ Grandparents ☐ Other _____
Explain Relationship

Mother's /Female Guardian's Name: _____ **Date of Birth:** ____/____/____
First Name Last Name Month Day Year

Work Phone #: _____ **Cellular Phone #:** _____
Area code Number Area code Number

SS#: _____ **Drivers Lic #:** _____

Father's /Male Guardian's Name: _____ **Date of Birth:** ____/____/____
First Name Last Name Month Day Year

Work Phone #: _____ **Cellular Phone #:** _____
Area code Number Area code Number

SS#: _____ **Drivers Lic #:** _____

Primary Insurance Information

Subscriber Name: _____ **Date of Birth:** ____/____/____
First Name MI Last Name Month Day Year

Relationship to patient: ☐ Self ☐ Bio. Parent ☐ Step Parent ☐ Relative _____
Explain Relationship

Address (*if different than Patients*): _____
House Number Street Apt # City State Zip

Residence Phone #: _____ **Work Phone #:** _____
Area code Number Area code Number

Employer: _____ ☐ Hourly ☐ Salary

Insurance Co.: _____ **Phone #:** _____
Area code Number

Group #: _____ **SS# or Contract #:** _____

Secondary Insurance Information

Subscriber Name: _____ **Date of Birth:** ____/____/____
First Name MI Last Name Month Day Year

Relationship to patient: ☐ Self ☐ Bio. Parent ☐ Step Parent ☐ Relative _____
Explain Relationship

Address (*if different than Patients*): _____
House Number Street Apt# City State Zip

Residence Phone #: _____ **Work Phone #:** _____
Area code Number Area code Number

Employer: _____ ☐ Hourly ☐ Salary

Insurance Co.: _____ **Phone #:** _____
Area code Number

Group #: _____ **SS# or Contract #:** _____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

Clinton Dental Center
Roman R. Sadikoff, D.D.S., PLLC

IN CASE OF EMERGENCY (Name of someone at an address different from yours)

Name:_____

Phone #: (_____)_____ Relationship:_____

Notice to Patients Regarding Office Policies:

- This office maintains a standard fee schedule.
- Financial responsibility for children with divorced or separated biological parents lies with ***both parents*** regardless of who brings the child in.
- Patients assisted dental insurance should remember that professional services are rendered and charged to the patient (or responsible party) and not to the insurance company. Your dental insurance program is a contract between the subscriber, the employer, and the insurance company. Even though an insurance claim is filed, a statement will be sent each month if the account has a balance due.
- Payment is required the day services are rendered. We accept Cash, Check (with valid Michigan ID), Visa, Master Card, Discover, American Express and Care Credit.
- A $25.00 fee is assessed to all checks returned NSF.
- Any account over 120 days delinquent may be sent for collections.
- Broken appointments or those canceled ***without a 48 hour notice*** will incur a charge of $25.00 per ½ hour of scheduled time.

By signing this form, I verify that the information given by me on the other side is true and correct to the best of my knowledge. I understand the above information and accept that I am responsible for the total fee for services rendered regardless of insurance benefits, including service charges and broken appointment fees.

I hereby authorize the release of information to the medical and or dental insurance company regarding services rendered to the patient and authorize benefit payment directly to Dr. Roman R. Sadikoff, PLLC.

Signed: X_____ **Date:**_____

Relationship to Patient:_____

ClintonDentalCenter
Roman R. Sadikoff, D.D.S. **Name:**_____ **Date:** ____/____/____

Medical History

PLEASE CIRCLE

Are you currently under a doctor's care now? If yes, explain _____ YES NO

Medical doctor's name and phone # _____

Have you been hospitalized during the past two years? If yes, explain _____ YES NO

Are you allergic to any substances or medications? If yes, list name(s) _____ YES NO

_____

Are you currently taking any medications? If yes, listname(s)and dosage(s) (additional space provided on back of this form)____ YES NO

_____

If female, are you taking birth control pills? (Antibioticsmay decrease the effectiveness of birth control pills.)_____ YES NO

If female, are you pregnant? If yes, what trimester are you in?_____ YES NO

Indicate which of the following you have had, or have at the present time. Circle YES orNO.

Heart- Surgery, Disease, Attack	YES NO	Stroke_____	YES NO	Hay Fever / Sinus Trouble___	YES NO
Chest Pain _____	YES NO	Epilepsy / Seizures _____	YES NO	Emphysema_____	YES NO
Congenital Heart Disease_____	YES NO	Neurological Disorder _____	YES NO	Chronic Cough_____	YES NO
Rheumatic Fever _____	YES NO	_____		Asthma_____	YES NO
Heart Murmur _____	YES NO	Psychiatric / Psychological Care	YES NO	Allergies / Hives _____	YES NO
Mitral Valve Prolapse_____	YES NO	Dizzy Fainting Spells_____	YES NO	Latex Sensitivity _____	YES NO
Artificial Heart Valve / Pace Maker	YES NO	Thyroid Problems_____	YES NO	Hepatitis—A (Infectious)_____	YES NO
Swollen Ankles _____	YES NO	Cold Sores _____	YES NO	Hepatitis—B (Serum) _____	YES NO
High Blood Pressure _____	YES NO	Arthritis / Rheumatism_____	YES NO	Liver Disease _____	YES NO
Low Blood Pressure_____	YES NO	Lupus _____	YES NO	Hemophilia/ Bleed Easily___	YES NO
Kidney Trouble _____	YES NO	Cortisone Shots / Steroids ____	YES NO	Sickle Cell Anemia_____	YES NO
Transplant / Implant _____	YES NO	Cancer_____	YES NO	Blood Transfusion_____	YES NO
Artificial Joints / _____	YES NO	Radiation / Chemotherapy____	YES NO	Venereal Disease _____	YES NO
Diabetes_____	YES NO	Take Bisphosphonates Meds___	YES NO	H I V Positive / A.I.D.S._____	YES NO
Hypoglycemia _____	YES NO	Do you use recreational drugs or herbs _____			YES NO
Diet— Special / Restricted____	YES NO	Do you smoke? How much? _____			YES NO
_____		Do you chew tobacco? How much?_____			YES NO

Any other serious illness not mentioned above? If yes, please describe in detail_____ YES NO

_____

Do you wish to talk to the doctor about a specific problem or concern?If yes explain_____ 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 the above 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 / Parent / Legal Guardian Signature:_____ Date:_____

FOR OFFICE USE ONLY

Reviewed by:_____ Date:_____ Reviewed by:_____ Date:_____

Reviewed by:_____ Date:_____ Reviewed by:_____ Date:_____

Reviewed by:_____ Date:_____ Reviewed by:_____ Date:_____

Reviewed by:_____ Date:_____ Reviewed by:_____ Date:_____

4/21/15

COMPLETE BACK SIDE ALSO

Describe the primary reason for your visit, How long has this been going on and what would you like done?

_____

_____

If you could rate your smile from 1-10, what would it be? _____

Would you like to improve your smile? Y N How? _____

_____

Have you ever suffered from, or been told you may have any of the following:

Gum Disease	NO	YES	Sleep Apnea	NO	YES
Bruxism or Grinding	NO	YES	Bad Breath	NO	YES
Jaw pain or TMJ	NO	YES	Headaches or Migraines	NO	YES
Snoring	NO	YES	Tooth Sensitivity to Hot/Cold	NO	YES

CHILDREN ONLY

Respiratory History Questionnaire

Does the Patient:

Have allergies to
- Seasonal grasses ..... NO YES
- Food ..... NO YES
  - What: _____
- Drugs ..... NO YES
  - What: _____

Breathe through mouth ..... NO YES
- Snore when sleeping ..... NO YES
- Have frequent colds ..... NO YES
- Have frequent "stuffy nose" ..... NO YES
- Have frequent sore throat or tonsillitis ..... NO YES
- Have chewing or swallowing difficulties ..... NO YES

ADDITIONAL MEDICATIONS: (From front questions)

Name & Strength (mg)	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pediatric TMJ/Airway-Sleep Screening Form

Patient Name:_____ **Date:**_____

Please indicate if your child experiences any of the following:

- □ Snoring
- □ Difficulty falling asleep
- □ Difficulty staying asleep
- □ Restless sleep
- □ Night terrors
- □ History of respiratory infections (ear, nose, throat)
- □ Chronic Mouth breathing
- □ Bed wetting
- □ Dental crowding
- □ Speech difficulties
- □ Excessive daytime sleepiness

Parent Signature:_____ Date:_____

Below line for clinical use only

JVA QUICK Completed: Yes □No□Openbite:_____ OB___mmOJ.mm

□Dental Crowding □Frenum Pulls □Narrow Arch Forms

Range of Motion Measurements:

Lateral Excursion Right _____mm Interincisal Opening (with pain) _____ mm

Lateral Excursion Left _____mm Interincisal Opening (w/o pain) _____ mm

Protrusive _____ mm

By:_____ (initials) **Date:**_____

CLINTON DENTAL CENTER

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

SECTION A: Patient(s) giving consent

Name(s): _____ Telephone:_____

Address:_____City:_____ Zip:_____

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 (PHI) 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 to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your PHI, and of other important matters about your PHI.

We reserve the right to change our privacy practices, including any revisions of our Notice, at any time.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, by contacting: Debra H., 50475 Gratiot, Suite #4, Chesterfield, MI 48051. Phone: 586-949-5363, e-mail: clintondentalctr@sbcglobal.net

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 this 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, **(print name)**_____, 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 PHI to carry out treatment, payment activities and health care operations.

Signature: X_____ Date: _____

If a personal representative on behalf of the patient(s) signs this Consent, complete the following:

Person Representative's Name: _____

Relationship to the Patient: _____

I authorize Clinton Dental Center to discuss my treatment and or health care with the following people:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOUR SIGN IT.

This completed original Consent Form will be retained in the patient's chart. If more than one patient is listed, a copy will be placed in each additional patient's charts.