LakePointe Orthodontics
Patient Friendly...Committed to Excellence

WILLIAM KRIEG DDS, MS
BRYNN JEZDIMIR DDS, MS
Orthodontic Specialists

GET ACQUAINTED QUESTIONNAIRE
ADULT

The following information is needed to enable us to give you the most consideration and best service possible. This information is, of course, confidential. Thank you.

Patient's full name ____________________ Date of Birth __________ Age _______ Phone _________
Address ___________________________ City ________________ State _________ Zip _____________
Email Address _________________________________ Cell Phone ______________________________
Family Dentist ___________________ City ________________ Phone ____________ Last Visit: _________
Family Physician ______________________ City ________________________ Phone _______________
Name patient likes to be called ________________________________
Sports, Hobbies, etc. ____
Single __________ Married ___________ Separated __________ Divorced __________ Widowed __________
Children (names/ages) ____
Major reason for seeking orthodontic treatment ____
How did you hear about our office? ____

DENTAL HISTORY

	No	Unsure	Yes	notes
Have there been any injuries to the face, mouth or teeth?..........	☐	☐	☐	notes: ____________
Are you aware of any missing or extra permanent teeth?...........	☐	☐	☐	notes: ____________
Do you have any speech problems or concerns?	☐	☐	☐	notes: ____________
Are you especially apprehensive toward dental visits?	☐	☐	☐	notes: ____________
Do you:				
• clench or grind your teeth?	☐	☐	☐	notes: ____________
• brush your teeth conscientiously?................................	☐	☐	☐	notes: ____________
Do you have:				
• a history of periodontal (gum) problems?	☐	☐	☐	notes: ____________
• a problem with frequent cold/canker sores?	☐	☐	☐	notes: ____________
• any difficulty opening your mouth?	☐	☐	☐	notes: ____________
• any clicking or discomfort in jaw joints near ears?...........	☐	☐	☐	notes: ____________
• headaches or neckaches regularly?	☐	☐	☐	notes: ____________
• pain in the jaw joints while eating?................................	☐	☐	☐	notes: ____________
• any congenital abnormalities? (cleft palate, etc.)............	☐	☐	☐	notes: ____________

ATTITUDE TOWARD TREATMENT

Are you aware of spaced, crooked or protruding teeth?............... ☐ No.... ☐ Yes Concerned?..... ☐ No... ☐ Yes
Do you feel that it is becoming .... ☐ Better......... ☐ Worse........... ☐ Staying the Same
What would you most like to have orthodontic treatment accomplish? ______________________________
Are you aware that some appointments will infringe upon school/work time?................ ☐ No........ ☐ Yes
Have you had any previous orthodontic examinations?.......... ☐ No....... ☐ Yes.... Doctor: __________ Date: _______
Have you had any previous orthodontic treatment? ________ Describe: ______________________________

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

Please check no or yes to the following and indicate the year:

	No	Yes	Years
Attention Deficit Disorder			
Allergies			
Anemia or Bleeding Problems			
Arthritis			
Asthma			
Behavioral Problems			
Bone or Joint Disorder			
Breathing or Nasal Disorder			
Diabetes			
Earaches			
Epilepsy or Convulsions			
Fainting or Dizziness			
Gagging or Nausea Problems			
Growth or Endocrine Condition			
Hay Fever			
Healing Disorder			
Headaches			
Hearing Disorder			
Heart Disorders (murmur, etc.)			
Hepatitis or Liver Disorders			
HIV Positive			
Kidney or Bladder Condition			
Mononucleosis			
Nervous Disorders			
Psychiatric Treatment			
Psychological Disorder			
Rheumatic Fever			
Sexually Transmitted Infection			

General health: Good________ Fair________ Poor________ Birth Defects________________

Presently under medical care for________________________________

Drugs or medication being taken now (drug and dose)________________________

Allergic to any medication________________________________

Do you require antibiotic premedication prior to dental appointments?......... ☐ No.... ☐ Yes

Are you a mouth breather?............................ ☐ No...... ☐ Yes.............. ☐ While asleep.......... ☐ While awake

Have tonsils and adenoids been removed?.... ☐ No...... ☐ Yes.............. At what age?____________

Do you snore at night?.................................. ☐ No..... ☐ Yes

RESPONSIBLE PARTY INFORMATION

Name ________________________________

Residence ________________________________ Zip

Mailing Address ________________________________ Zip

How long at this address __________ Home Phone __________ Work Phone __________

Social Security #__________ Birthdate __________ Relationship to Patient__________

Employer __________ Occupation __________ No. Years Employed __________

Spouse's Name ____________________ Relationship to Patient __________

Spouse's Address ________________________________

Employer __________ Occupation __________ No. Years Employed __________

Social Security # __________ Birthdate __________ Work Phone __________

Emergency contact person ________________________________

Name Home Phone Work Phone

ORTHODONTIC INSURANCE INFORMATION

Insurance Company __________ Group No. __________ Local No. __________

Insurance Co. Address ________________________________

Insured's Name ____________________ Insured's Soc. Sec. # __________

Insured's Employer ________________________________

Do you have dual coverage? ☑ No ☐ Yes If Yes:

Insurance Company __________ Group No. __________ Local No. __________

Insurance Co. Address ________________________________

Insured's Name ____________________ Insured's Soc. Sec. # __________

Insured's Employer ________________________________

I understand that where appropriate, credit bureau reports may be obtained.

Signature of parent or guardian ____________________ Date __________

I give permission for x-rays and photographs to be used for research/educational purposes __________

Initials

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 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 HIPPA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that JIPPA requires is to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discuss 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 of 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 disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory got 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.

I have acknowledged that I have today received a copy of the Notice of Privacy Practices.

____________________	____________________	____________________
Signature (patient or if minor, parent)	Patient Name (please print)	Date

FOR OFFICE USE ONLY

Patient Refused to Sign

The following circumstances prohibited the patient for signing the Acknowledgment: ____________________

____

_____An emergency situation prevented the patient from signing the Acknowledgment.

____________________	____________________	Date: ____________________
Office Personnel (signature)	Office Personnel (print)	

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.

____________________	____________________	____________________
Signature (patient or if minor, parent)	Patient Name (please print)	Date

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OUR APPOINTMENT POLICY

WELCOME ABOARD!

We are pleased that you are considering our practice to serve your orthodontic needs. Please know that we are committed to providing a patient-friendly experience that results in a healthy, beautiful smile for a lifetime. We are always available for questions or comments and greatly appreciate your feedback. Since orthodontic treatment is a team effort, we have prepared this handout to help you become more familiar with certain office policies.

OFFICE SCHEDULE/HOURS

We are open from 8:00 a.m. to 5:00 p.m. Monday through Thursday with our later night on Wednesday (5:30 p.m.), and some Fridays. We answer the phone throughout the lunch hour and on Fridays from 8:00 a.m. to 5:00 p.m. We are closed on weekends and major holidays as well as certain days for continuing education.

APPOINTMENTS

Our appointment policy was developed in an effort to give everyone the very best service that we can. Your appointment with us means we have reserved a dental operatory, equipment, supplies and an orthodontic technician to help you/your child's treatment move forward that day. We do our best to be on time for our patients and appreciate your prompt arrival so we can accomplish everything planned. **If you can not keep an appointment, please notify us as soon as possible by phone or text.**

All appointments, whether they are long or short, are very important and when missed, will often result in extending treatment time. **Additionally, failed or rescheduled appointments may result in the next visit being at a less convenient time.**

Our practice schedules longer appointments such as placing/removing braces and appliances in mid-morning and early afternoon. Shorter visits are usually scheduled in the mid to later afternoon or "early-bird" hours (8-9 a.m.). This enables us to see more patients during "prime times" (3-5:30 p.m.).

We strive to see all patients at their scheduled appointment time! **It is important for you to arrive on time.** If you are 15 or more minutes late, we will make accommodations to see you, though there may be a wait for you/your child to be seen. Also, we will do our best to accomplish as much of your planned procedure as possible, though we may need to reschedule any major procedures.

URGENT CARE

We reserve time each day so that a patient with an orthodontic urgency may be scheduled quickly. If you have a problem requiring urgent care, please call us as early in the day as possible. Please note that these appointments are usually scheduled in the morning, early afternoon or at lunch time.

Should you have an urgency after hours or on weekends, we have an orthodontic technician on call who can be reached via cell phone at (586) 306-2106.

__________Initials of responsible party

Orthodontic treatment is a process that requires great teamwork.
Thank you in advance for allowing us to be part of your healthcare team!

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