SWISS DENTAL

SOUTHFIELD

NEW PATIENT REGISTRATION

20100 W 12 Mile Rd, Southfield, MI 48076
(248) 353-5010

Please complete all applicable fields before your appointment. This fillable form may be completed on a phone, tablet, or computer.

Patient Information

First Name | Last Name | Middle Initial | Preferred Name

Date of Birth | Age | Social Security # (optional) | Driver's License #

Street Address | Apt / Unit | City | State | ZIP

Mobile Phone | Home Phone | Email

Sex: ☐ Male ☐ Female ☐ Other / Prefer not to say

Responsible Party (if different from patient)

Full Name | Relationship | Phone

Address (if different) | Employer

Employment / Preferences

Employer | Preferred Pharmacy

How did you hear about us?

☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Primary Dental Insurance

Insurance Company | Member / Subscriber ID | Group #

Policyholder Name | Policyholder DOB | Relationship to Patient

Secondary Dental Insurance (if applicable)

Insurance Company | Member / Subscriber ID | Group #

Policyholder Name | Policyholder DOB | Relationship to Patient

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MEDICAL HISTORY

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Your health information can affect dental treatment. Please answer each question and provide details where requested.

General Health

Are you currently under a physician's care?	☐ Yes	☐ No
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No
Have you ever had a serious head or neck injury?	☐ Yes	☐ No
Are you currently taking any medications, pills, vitamins, or drugs?	☐ Yes	☐ No
Have you ever taken Fen-Phen or Redux?	☐ Yes	☐ No
Have you ever taken Fosamax, Boniva, Actonel, or another bisphosphonate?	☐ Yes	☐ No
Are you on a special diet?	☐ Yes	☐ No
Do you use tobacco or nicotine products?	☐ Yes	☐ No
Do you use controlled substances?	☐ Yes	☐ No

If YES to any question above, please explain:

Current medications (name, dose, reason):

Primary physician / practice

Physician phone

Allergies

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics

Other allergies / reactions

Women / Pregnancy (if applicable)

- ☐ Pregnant / trying to become pregnant
- ☐ Nursing
- ☐ Taking oral contraceptives

Other health information, serious illness, or details your dental team should know

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MEDICAL CONDITIONS

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Check each condition that applies to you now or has applied in the past. Leave unchecked if it does not apply.

Medical Conditions

- [ ] AIDS/HIV Positive
- [ ] Alzheimer's Disease
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Angina
- [ ] Arthritis/Gout
- [ ] Artificial Heart Valve
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Breathing Problems
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chest Pains
- [ ] Cold Sores/Fever Blisters
- [ ] Congenital Heart Disorder
- [ ] Convulsions
- [ ] Cortisone Medicine
- [ ] Diabetes
- [ ] Drug Addiction
- [ ] Easily Winded
- [ ] Emphysema
- [ ] Epilepsy/Seizures
- [ ] Excessive Bleeding
- [ ] Excessive Thirst
- [ ] Fainting/Dizziness
- [ ] Frequent Cough
- [ ] Frequent Diarrhea
- [ ] Frequent Headaches
- [ ] Genital Herpes
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Heart Attack/Failure
- [ ] Heart Murmur
- [ ] Heart Pacemaker
- [ ] Heart Trouble/Disease
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Hepatitis B or C
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Hives or Rash
- [ ] Hypoglycemia
- [ ] Irregular Heartbeat
- [ ] Kidney Problems
- [ ] Leukemia
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lung Disease
- [ ] Mitral Valve Prolapse
- [ ] Osteoporosis
- [ ] Pain in Jaw Joints
- [ ] Parathyroid Disease
- [ ] Psychiatric Care
- [ ] Radiation Treatments
- [ ] Recent Weight Loss
- [ ] Renal Dialysis
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Scarlet Fever
- [ ] Shingles
- [ ] Sickle Cell Disease
- [ ] Sinus Trouble
- [ ] Spina Bifida
- [ ] Stomach/Intestinal Disease
- [ ] Stroke
- [ ] Swelling of Limbs
- [ ] Thyroid Disease
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Tumors or Growths
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Endocarditis
- [ ] Alcohol/Drug Abuse

Comments / Details

Please explain any checked condition that may require more detail:

Additional comments

I certify that the medical information above is accurate to the best of my knowledge.

- [ ] I agree

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CONSENTS, PRIVACY & SIGNATURES

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Review the statements below. Complete the authorization details and sign by typing your full legal name.

HIPAA Authorization for Release of Identifying Health Information

I authorize Swiss Dental Southfield and its dental professionals to disclose health information identifying me, including, when applicable, information concerning HIV/AIDS, substance-use treatment, mental health services, and other protected health information, only as described below. I understand that I may refuse to sign this authorization and that treatment will not be conditioned on signing it, except where permitted by law.

1. Information to be released

2. Recipient(s) / organization(s)

3. Purpose of the release

4. Expiration date or event

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy rules.

Consent for Treatment & Financial Responsibility

I authorize Swiss Dental Southfield, its dentists, hygienists, assistants, and associates to perform examinations, take x-rays and photographs, use diagnostic aids, administer local anesthesia when indicated, and provide dental treatment that is recommended and agreed upon. I understand that dental treatment and anesthetic agents involve risks and that I may ask questions about proposed treatment, alternatives, benefits, risks, and possible complications before treatment.

I authorize the practice to release information necessary for treatment, payment, and health care operations and to submit claims to my insurer. I request that insurance benefits, when applicable, be paid directly to the practice. I understand that insurance estimates are not guarantees of payment and that I am responsible for balances not paid by insurance, including amounts for services rendered to me or my dependents.

Cancellation Policy

A minimum of 48 hours' notice is requested to cancel or change an appointment. The practice may charge a fee for late cancellations or missed appointments. After repeated broken appointments, a deposit may be required before scheduling another appointment, and the practice may discontinue non-emergency care when appropriate.

Patient Acknowledgment & Electronic Signature

By typing my full legal name below, I certify that the information I provided is accurate to the best of my knowledge, I agree to inform the office of material changes in my health or insurance information, and I acknowledge that I have read and understand the authorizations and policies above.

☐ I agree to use my typed name as my electronic signature.

Patient / Parent / Guardian Full Legal Name

Date

Relationship to Patient (if not patient)

Practice note: Have your dental practice's attorney or compliance advisor review privacy, consent, fee, and electronic-signature language before publishing, especially if your website stores or transmits protected health information.