



SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

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 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 whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Todd Gustke, Director Human Resources
Telephone: (248) 203-1100
Fax: (248) 203-1112
E-mail: todd.gustke@greatexpressions.com
Address: 300 E. Long Lake Road, Suite 311, Bloomfield Hills, MI 48304

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 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.

SECTION C: SIGNATURE

I, _____ 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 protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) _____

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.



PATIENT NAME _____ DATE _____

Great Expressions Dental Centers and affiliated companies, collectively known as "GEDC," are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.
- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS®, VISA®, MASTERCARD®, DISCOVER® AND CARE CREDIT®.
- GEDC PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to American Express, VISA, MasterCard or Discover.

INSURANCE

GEDC provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by GEDC staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to GEDC. However, if you are paid by the insurance company instead of GEDC, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You, as a patient, are always responsible for any charges that are not covered by your insurance.

MEDICARE/ MEDICAID/ CHAMPUS/ WORKERS' COMPENSATION

If you are covered by Medicare, Medicaid, Champus, Workers' Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to date of service.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of \$25.00.

MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of \$35.00 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____ Date _____

ORTHODONTIC PATIENT REGISTRATION

GREAT EXPRESSIONS ORTHODONTIC CENTERS



PATIENT INFORMATION

Patient's Full Name _____ Patient is Male Female Patient's Birth Date _____
First, Middle, Last Month/Day/Year

Patient's Address _____ Home Phone (____) _____
Street City State Zip

Patient's Dentist _____ Dentist's Phone (____) _____
Name City

Whom may we thank for your referral? _____ Other family members seen by us? _____

RESPONSIBLE PARTY INFORMATION

Parent 1 Name _____ (Single Married Divorced) Relationship to Patient _____
First, Middle, Last

Home Address _____ Home Phone (____) _____
Street City State Zip

Employer and Occupation _____ Birthdate _____ Social Security No. ____/____/____
Month/Day/Year

E-mail Address _____ Work Phone (____) _____ Cell Phone (____) _____

Parent 2 Name _____ (Single Married Divorced) Relationship to Patient _____
First, Middle, Last

Home Address _____ Home Phone (____) _____
Street City State Zip

Employer and Occupation _____ Birthdate _____ Social Security No. ____/____/____
Month/Day/Year

E-mail Address _____ Work Phone (____) _____ Cell Phone (____) _____

Primary Insurance & Subscriber _____ Secondary Insurance & Subscriber _____

HEALTH HISTORY

MEDICAL HISTORY - Please check "Yes" or "No" to all items below

Yes No ADHD/ADD Meds: _____

Yes No Asthma (if so, what medication(s)? _____

Yes No Girls: Started menstruation? First Cycle: _____

Yes No Boys: Voice changed?

Yes No Heart Trouble/Heart Murmur

Yes No Artificial Joints

Yes No Joint Swelling or Arthritis

Yes No Prolonged Bleeding

Yes No Endocrine Problems

Yes No Diabetes

Yes No Bone Disorders

Yes No Rheumatic Fever

Yes No Hepatitis or Liver Problem

Yes No Tuberculosis (TB)

Yes No AIDS or HIV

Yes No Epilepsy

Yes No Tonsils Removed (If so, when?) _____

Yes No Are you pregnant? How far along? _____

Yes No Allergies Seasonal Meds: _____
 Drugs: Which Ones? _____
 Latex Nickel Nuts

DENTAL HISTORY - Please check "Yes" or "No" to all items below

Yes No Any injuries to face, mouth, teeth?

Yes No Thumb, finger or lip sucking habit(s)?
Discontinued at age _____

Yes No Mouth breathing when awake, asleep?

Yes No Any known missing permanent teeth?

Yes No Any known extra permanent teeth?

Yes No Any teeth removed by extraction? If so, when _____

Yes No A tongue thrust problem? Speech problems?

Yes No Any clenching or grinding of teeth? Day Night Both

Yes No Any pain, popping or locking on opening or closing jaw?

Yes No Frequent headaches? If so, number per week ____ AM PM

Yes No Any muscle tenderness or stiffness in the jaw neck?

Yes No Any ringing sounds in the ear or spells of dizziness?

Yes No Any previous treatment for TMJ or jaw point problems?

Yes No Any previous orthodontic evaluation or treatment?

Yes No Are you under doctor's care now?
For what? _____
Name of Physician: _____

Allergies - Other: _____

Date of last dental cleaning: _____

PLEASE LIST YOUR **CHIEF CONCERN(S)** AND WHAT YOU WOULD LIKE TREATMENT TO ACCOMPLISH:

Signature of Person Completing Form: _____ Date: _____

Updated Health History/ Personal Information: Date: _____ Date: _____ Date: _____ Date: _____ Date: _____
Initials: _____ Initials: _____ Initials: _____ Initials: _____ Initials: _____