BRETON GARDENS
FAMILY DENTISTRY

HEATHER MALLORY-MAY, D.D.S.
DAVID MAY, D.D.S.

Dear Patient,

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are sincere about providing quality dental care at reasonable cost and are proud of our dedication to our patients. Our goal is to help you look and feel the very best through excellent dental care.

For your initial appointment, we plan approximately 90 minutes. We will complete a comprehensive exam and take necessary x-rays to discuss your individual needs and circumstances regarding your dental health. Together we will make decisions about necessary treatment. **To facilitate being seen just as soon as possible, we suggest completing the enclosed forms in the comfort of your home where pertinent information, names and numbers, medication list, insurance information, etc will be nearby.** Please arrive 10 minutes early to allow time for us to assemble your chart.

If you are unable to keep this appointment, please notify us **24 hours** in advance. We look forward to meeting you and serving your needs.

While we welcome new patients to our practice, it is necessary that any patient under age 18 be accompanied by a parent/legal guardian. If a minor child needs to be accompanied by anyone other than a parent or guardian, a signed permission slip would be required.

Sincerely,

Family Dentistry Staff
Heather Mallory-May, D.D.S.
David E. May, D.D.S.

Reminder: Please bring insurance cards/forms with you for this appointment. We will collect any co-pays or deductibles due at the time of your appointment. Thank you.

4144 BRETON ROAD S.E.
KENTWOOD, MI 49512
616.455.0720 fax: 616.455.0815
www.bretongardensfamilydentistry.com

WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #:____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate:____/____/____ Age:_____ SS#: _____

Mailing Address:_____

_____
CITY STATE ZIP

Home Phone #: (_____)_____

Work Phone #: (_____)_____ Ext:_____

Cell Phone #: (_____) _____

E-mail Address:_____

Referred By: _____

Employer:_____How Long?_____

Employer's Address:_____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address:_____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Relation:_____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address:_____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Relation:_____ Date of Birth: ____/____/____

Insured's Employer: _____

three ACCOUNT INFO

Person ultimately responsible for account

Name:_____

Relation: _____

Billing Address:_____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____)_____

Payment method: ❑ Cash ❑ Check

_____ ____/____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

four IN EVENT OF EMERGENCY

Whom should we contact?_____

Relation: _____

Home Phone #: (_____)_____

Work Phone #: (_____)_____

Cell Phone #: (_____)_____

Who is your Medical Doctor?_____

Medical Doctor's Phone #: (_____)_____

PLEASE CONTINUE ON BACK

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DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth

❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw

❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath

❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ (____) _____
Name Phone#

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

six 6

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

What medications are you taking? ❑ **Nerve pills** ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**
❑ **Other(s), please list:** _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin

❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

Initials ____ Date ____/____/____

Comments

Initials ____ Date ____/____/____

Comments

Initials ____ Date ____/____/____

Comments

David May and Heather Mallory-May, D.D.S.
4144 Breton Road SE, Kentwood, MI 49512, (616)455-0720

I have read and understand Drs. May, Mallory-May and Breton Gardens' Financial Policy.

I certify that the insurance information that I have given is correct. I will notify Breton Gardens Family Dentistry of any future changes in my dental insurance. I authorize the release of any dental information necessary in order to process a claim with my insurance company and authorize payment made directly to Drs. May, Mallory-May and Breton Gardens.

Please list all family members or other persons that Breton Gardens may discuss, the patient listed on this form, any general dental information including; treatment, payment and dental care appointments.

_____ _____

_____ _____

I authorize the release of information needed in case of a referral to a specialist. Yes _____ No _____

Please print the address (if other than your home) where you would like correspondence from our office.

_____

Do you prefer a postcard from our office to be enclosed in a sealed envelope marked confidential? Yes _____ No _____

Please print the telephone number (if other than your home number) where you would like to receive calls regarding your appointment.

_____*Please remember to update information if your number changes.*

note: a cell phone is not a secure and private line

Can confidential messages (ie: appointment reminders) be left on your answering machine or voicemail? Yes _____ No _____

PATIENT NAME _____

PARENT/GUARDIAN _____ (if patient is under 18)

SIGNATURE _____ DATE _____

OPTIONAL: Please complete the following information if you would like us to keep your credit card information on file to pay for charges at the time of service or for balances after insurance pays.

Card Number: _____ Type: VISA MASTERCARD DISCOVER

Name on card: _____ CVS# _____ Expiration Date: _____

Signature: _____ Today's Date: _____

REVISED 01/03/2008

MAY, MALLORY AND ASSOCIATES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about your for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your heath information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities. Reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to us your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by authorization while it is in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use of disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement regarding healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best

interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your heath information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim or abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies on a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If your request copies, we will charge you $0 _____ for each page $ per hour for staff time to locate and copy your health info___ illation, and postage if you want the copies mailed to you. If your request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary fan explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information.. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.