Total Smiles
DENTAL GROUP
OF CHELSEA

WELCOME TO TOTAL SMILES DENTAL GROUP OF CHELSEA!!

WE ARE PLEASED THAT YOU HAVE SELECTED OUR PRACTICE FOR YOUR DENTAL NEEDS. WE STRIVE TO PROVIDE A HIGH LEVEL OF SATISFACTION TO OUR PATIENTS. SHOULD WE EVER NOT MEET YOUR EXPECTIONS, PLEASE LET US KNOW. AT TOTAL SMILES WE WANT TO GIVE EVERY PATIENT THE HIGHEST QUALITY OF CARE POSSIBLE. OUR STAFF MEMBERS ARE HERE AND TRAINED TO HELP YOUR DENTAL VISIT BE A PLEASEANT EXPERIENCE. PLEASE HELP US DO OUR JOB, BY ANSWERING THE FOLLOWING QUESTIONS FOR YOU AND YOUR FAMILY MEMBERS.

1. HOW OR WHERE DID YOU HEAR ABOUT OUR PRACTICE?

   _____

2. IF A CURRENT PATIENT OF RECORD REFERRED YOU. MAY WE SEND THEM A THANK-YOU CARD AND $10.00 GIFT CARD FOR THE REFERRAL AND MENTION THAT YOU CAME TO SEE US BECAUSE OF THEM? YES / NO

3. WE SEND OUT EMAIL AND TEXT MESSAGE CONFIRMATIONS, APPOINTMENT REMINDERS, AS WELL AS EXCLUSIVE OFFERS FOR OUR PATIENTS AND PROMOTIONS; WOULD YOU LIKE TO RECEIVE THESE SERVICES? YES / NO

4. IF YOU ANSWERED YES, MAY WE HAVE YOUR EMAIL ADDRESS:

   _____

5. MAY WE HAVE YOUR CELL PHONE TO SEND YOU TEXT MESSAGE APPOINTMENT REMINDERS? YES / NO

   CELL NUMBER: _____

6. WAS OUR STAFF PLEASANT ON THE PHONE? YES/ NO

7. DID THEY ANSWER YOUR QUESTIONS TO YOUR SATISFACTION? YES /NO

8. IS THERE ANY OTHER CONCERN OR ISSUE, WE CAN ASSIST YOU WITH?

_____
_____
_____
_____
_____

THANK YOU FOR YOUR TIME IN FILLING OUT THIS SURVEY. SHOULD YOU HAVE ANY QUESTIONS, PLEASE ASK TO SPEAK TO OUR PRACTICE MANAGER: LISA BINION AT ANY TIME. YOU CAN ALSO CALL OUR OFFICE AT 1-734-475-7303
OR EMAIL LISA AT: binionlisa@aol.com .

Adjunctive Oral Cancer Screening Acceptance Form

Complete each time the examination is performed and place in the patient's file

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors.**

Oral Cancer Risk profile

Increased risk

- Patients age 40 and older (95% of all cases)
- 18-39 years of age combined with any of the following:
  - Tobacco use
  - Chronic alcohol consumption
  - Oral HPV infection

Highest risk

- Patients age 65 and older with lifestyle risk factors
- Patients with history of oral cancer

- **25% of oral cancers occur in people who don't smoke and have no other risk factors.**

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for this enhanced examination is $65.00.

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____

Total Smiles Dental Group

Family Dentistry

PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Date _____ Cell Phone _____

E-Mail Address _____ Home Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: ❑ M ❑ F Age____ Birthdate_____ Driver's License#_____ ❑ Single ❑ Married ❑ Divorced

Patient Employed by _____ Patient Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Patient Social Security # _____ Spouse/Parent Social Security # _____

Dental Insurance Company 1) _____ 2) _____ Group #s _____

In Case of Emergency, Contact _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check all that apply)

- ❑ Heart Problems
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Circulatory Problems
- ❑ Nervous Problems
- ❑ Radiation Treatment
- ❑ Artificial Heart Valves or Joints
- ❑ Recent Weight Loss
- ❑ Back Problems
- ❑ Diabetes
- ❑ Latex Allergy
- ❑ Eye Surgery
- ❑ Respiratory Disease
- ❑ Epilepsy
- ❑ Headaches
- ❑ Hepatitis, Jaundice or Liver Disease
- ❑ Cancer
- ❑ Psychiatric Care
- ❑ Chronic Diarrhea
- ❑ Allergies to Anesthetics
- ❑ Allergies to Medicines or Drugs
- ❑ General Allergies
- ❑ Blood Disease
- ❑ Arthritis
- ❑ Special Diet
- ❑ Swollen Neck Glands
- ❑ Sinus Problems
- ❑ A.I.D.S. or Other Immunosuppressive Disorders
- ❑ Stroke
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Chemical Dependency
- ❑ Hemophilia

Do you have ANY drug allergies or have you ever had an adverse reaction to ANY medication? If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking ANY medication at this time? _____ If so, what? _____

Are you currently under the care of a physician? ❑ Yes ❑ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ❑ Yes ❑ No Are you Nursing? ❑ Yes ❑ No

Is there anything else we should know about your medical history? _____

_____

_____

(over please)

DENTAL HISTORY

Previous Dentist (if applicable) _____ City _____

Date of last cleaning _____ Date of last dental visit _____ Why? _____

Have you had dental x-rays taken during the past three years? ☐ Yes ☐ No If so, what kind: _____

☐ Bitewings (one or two on each side to detect cavities) Date _____

☐ Complete Series (16 x-rays) Date _____

☐ Panorex (sitting or standing and machine moves around head) Date _____

Is there any condition in your mouth that is causing you pain or discomfort? ☐ Yes ☐ No If yes, what kind: _____

_____

Do you do any of the following? (check all that apply)

☐ Bite cheeks or lips	☐ Suck fingers	☐ Breathe through mouth	☐ Drink tea/coffee
☐ Bite tongue	☐ Bite fingernails	☐ Tongue thrust	☐ Chew tobacco
☐ Clench teeth	☐ Suck thumb	☐ Notice bad breath frequently	☐ Smoke (cig/pipe)

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

What can we do for you today? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Date _____ Signature _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Total Smile's Providers, all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date Signature of Insured/Guardian

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental staff
Name of minor/child

to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature of Insured/Guardian

FINANCIAL AGREEMENT

By signing below I acknowledge the following (1) I am responsible for any and all payments or co-payments for services rendered; (2) Any claims submitted to insurance, which are subsequently declined shall become my responsibility; (3) In the event my owed balance should become delinquent, I acknowledge I may additionally become responsible for additional fees including but not limited to: late fees, collection fees, interest, court costs and attorney fees.

_____ _____
Date Signature of Insured/Guardian

ATTENTION PATIENTS
AND
"RESPONSIBLE PARTY"

PAYMENT: for all treatment is due at the time of service.

Our options for payment are:

- CASH
- CHECK
- VISA
- MASTERCARD
- CARE CREDIT

MAJOR RESTORATIVE PROCEDURES

(Crown, Bridge & Denture & Root Canals)

Will require ½ of your co-payment to start treatment and the remaining balance is due in full at completion.

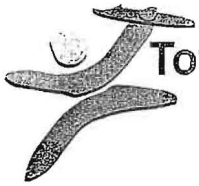
Thank you in advance for your review and understanding.....

Any questions please ask to speak to the Office Manager, Lisa Binion

NOTE:
If you are unable to pay your portion at the time of service, you appointment will need to be rescheduled.

I have reviewed and understand the payment policy at Total Smiles Dental Group, as outlined above.

X_____ Date:_____



Total Smiles Dental Group

Family Dentistry

OFFICE POLICY DECLARATION FORM

Total Smile's staff of qualified dentists, hygienists and other support personnel hope to provide you and your family with quality dental care for years to come. Our goal is to educate all of our patients to the best of our abilities about their dental needs. In order for us to accomplish this task, it is necessary that we also have the utmost cooperation of our patients to ensure their dental health does not become compromised. Our trained team will treat you and your family in the most professional manner and will always be willing to answer any questions you may have regarding your treatment or our office policies.

In assisting our team to accomplish Dr. Sherr's goal of dedication, a number of policies have been implemented to help us serve you better and ensure better overall patient care. We ask that you take a few minutes to review just a couple of these policies before we begin our relationship.

INSURANCE AND PAYMENT FOR SERVICES: We are primarily a "fee-for-service" dental practice however, we also accept patients who participate in a variety of dental insurance plans as well as patients who have no insurance at all. Regardless of a patient's insurance status, the **fees associated with any treatment will be due and expected at the time of service.** As a courtesy, we will make an honest effort to give those patients with insurance coverage an *estimate* of what they can expect their insurance to pay. The amount which is not covered by insurance (i.e. the "co-pay") will be expected to be paid by the insured at the time service is rendered. In any event and for whatever reason an insurance company declines to cover the cost of the treatment rendered in our offices, the **patient/insured will be responsible for the outstanding balance.** Although we will make every *reasonable* effort to obtain insurance benefits from the insurer, **the ultimate responsibility falls upon the patient/insured to resolve disputes with their insurance company(ies).** This is a contractual relationship between the patient and the insurer; not the insurer and the dental office. **We ask patients to direct ALL financial and/or treatment fee questions to the office Financial Coordinator or Office Administrator.**

SCHEDULED APPOINTMENTS: Patients' scheduled appointments are just that - **scheduled** appointments! We make every effort to arrange a convenient time for our patients to attend to their dental needs. Further, in an effort to remind patients of their appointments, an appointment card or recare card is given or sent, respectively, to our patients, as well as a courtesy phone call being made at least two (2) days prior to the scheduled appointment. Preferably, our office would like *48 hours notice* if you are unable to keep your scheduled appointment. ***At a minimum, we require 24 hours notice.*** In the event our patients are unable to give (at least 24 hours) notice that they cannot keep their scheduled appointment, a $18.00 (Eighteen $) charge **per appointment** will be assessed against their account to offset the overhead costs for this opening in the office's schedule. **We prefer not to charge this fee.** A simple call by you, the patient, will relieve you of this financial burden and allow our office to fill the opening with a patient in need of immediate dental care. Thank you in advance for your assistance in this matter.

PAYMENT: Our office accepts VISA, MasterCard and Discover for payment. We also accept cash, personal checks (no third-party checks), cashier's checks and money orders. Certain patients may qualify for time-payment contracts or a line of credit through, an independent finance company! If you have any questions regarding payment, please ask the office Financial Coordinator.

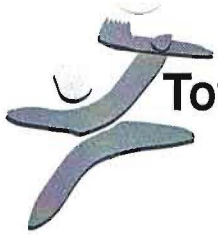
As a patient you have the responsibility to attend to your dental needs both at our offices and at home. Neglecting your dental needs can and surely will lead to greater complications as you get older. Our office will advise our patients of the recommended course of treatment - It is the patient's ultimate decision, however, whether or not he/she wishes to participate in this course of treatment.

I ACKNOWLEDGE I HAVE READ and REVIEWED THE ABOVE POLICIES OF TOTAL SMILES. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS REGARDING THESE MATTERS PRIOR TO BECOMING A PATIENT OF TOTAL SMILES.

DATED:_____

_____

Patient/Guardian Signature



Total Smiles Dental Group

Family Dentistry

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement) our offices to first obtain your written consent prior to disclosing any of your written information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review 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 other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures in connection with providing or coordinating your treatement.

PATIENT ACKNOWLEDGEMENT

You May Refuse to Sign This Acknowledgement

By signing below, I acknowledge I have today received a copy of this office's Notice of Privacy Practices.

_____ _____

Patient Signature Patient Name (Please Print)

_____

Date:

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)_____

PATIENT CONSENT

By signing below, I consent to the disclosures of my information, which your offices deem reasonably necessary in connection with my proper dental treatment. I understand such disclosures may not be of the type listed above.

_____ _____

Patient Signature Patient Name (Please Print)

_____

Date:

TOTAL SMILES DENTAL GROUP, LLC

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 (04/14/2003), 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 you 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 health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing, the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Michigan Law: Pursuant to Michigan Law, we are required to obtain your written consent prior to making certain disclosures of your health care information.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use 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 your authorization while it was 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 or 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 in your 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 health 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 of 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 heath 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 heath information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENTS RIGHTS

Access: Your have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in 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 you request copies, we will charge you a flat fee of $35.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in the format. If you prefer, we will prepare a summary or an 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.

Restriction: 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of the Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Hippa Security Officer

Telephone: (734) 475-7303

Address: 901 Taylor St., Suite A, Chelsea, MI 48118