Orthodontics for Adults and Children

Valmy P. Kulbersh, D.D.S., M.S., P.L.C.
Richard Kulbersh, D.M.D., M.S., P.L.C.
Board Certified Orthodontists

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call.

PATIENT INFORMATION ______ DATE ______

Patient Name ______ Birth date ____/____/____
LAST FIRST MIDDLE INITIAL

Address ______
STREET CITY STATE ZIP CODE

Home Phone (____) ______ Work Phone (____) ______ Cell Phone (____) ______

Whom does Patient live with? (**Minors Only**) ______ Driver's License # ______

Employer ______ Whom may we thank for referring you? ______

Martial Status: Married ____ Divorced ____ Separated ____ Remarried ____ Single ____ Widowed ____

Emergency Contact (**PERSON NOT LIVING WITH YOU**) ______ Phone Number (____) ______

PARENT INFORMATION -MINORS ONLY ______

MOTHER

Name ______ Birth date ____/____/____ Social Security # ______

Address ______
STREET CITY STATE ZIP CODE

Home Phone (____) ______ Work Phone (____) ______ Cell Phone (____) ______

Employer ______ Driver's License # ______

Martial Status: Married ____ Divorced ____ Separated ____ Remarried ____ Single ____ Widowed ____

FATHER

Name ______ Birth date ____/____/____ Social Security # ______

Address ______
STREET CITY STATE ZIP CODE

Home Phone (____) ______ Work Phone (____) ______ Cell Phone (____) ______

Employer ______ Driver's License # ______

Martial Status: Married ____ Divorced ____ Separated ____ Remarried ____ Single ____ Widowed ____

INSURANCE INFORMATION ______

PRIMARY INSURANCE

Name of Insured ______ Birth date ____/____/____ Relationship to Patient ______

Social Security Number ______ Employer ______ Work Phone (____) ______

Employer Address ______

Insurance Company Name ______ Phone (____) ______

Insurance Company Address ______

SECONDARY INSURANCE Name of Insured

Name of Insured ______ Birth date ____/____/____ Relationship to Patient ______

Social Security Number ______ Employer ______ Work Phone (____) ______

Employer Address ______

Insurance Company Name ______ Phone (____) ______

Insurance Company Address ______

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DENTAL HISTORY

Reason for today's visit ______________________ Date of last dental visit ____/____/____

Dentist ______________________ **Phone Number** ______________

Check if you have had any of the following:

__Bad breath	__Grinding teeth	__Injury to face, jaws or teeth
__Bleeding gums	__Loose teeth or broken fillings	__Sensitivity when biting
__Clicking or popping jaw	__Periodontal treatment	__Sores or growths in your mouth
__Food collection between teeth	__Sensitivity to cold or heat	__TMJ pain

How often do you floss? ______________ How often do you brush? ______________

MEDICAL HISTORY

Physician's Name ______________________ Date of last visit ____/____/____

Have you ever had any serious illnesses or operations? __Yes __No If yes, describe ______________

Have you ever had a blood transfusion? __Yes __No If yes, give approximate dates ______________

(Women) Are you pregnant? __Yes __No Nursing? __Yes __No Taking birth control pills? __Yes __No

Check if you have had any of the following:

__Anemia	__Cortisone Treatments	__Hepatitis	__Scarlet Fever
__Arthritis, Rheumatism	__Cough, Persistent	__High Blood Pressure	__Shortness of Breath
__Artificial Heart Valves	__Cough up Blood	__HIV/AIDS	__Skin Rash
__Artificial Joints	__Diabetes	__Jaw Pain	__Stroke
__Asthma	__Epilepsy	__Kidney Disease	__Swelling of Feet or Ankles
__Back Problems	__Fainting	__Liver Disease	__Thyroid Problems
__Blood Disease	__Glaucoma	__Mitral Valve Prolapse	__Tobacco Habit
__Cancer	__Headaches	__Pacemaker	__Tonsillitis
__Chemical Dependency	__Heart Murmur	__Radiation Treatment	__Tuberculosis
__Chemotherapy	__Heart Problems	__Respiratory Disease	__Ulcer
__Circulatory Problems	__Hemophilia	__Rheumatic Fever	__Venereal Disease

Medications:

List medications you are currently taking and the correlating diagnosis: ______________________

____

Allergies: ______________________________________

____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

______________________________ ______________________
Signature of patient or parent if minor Date

Payment is made in full at time of treatment unless prior arrangements have been approved

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Drs. Richard and Valmy Kulbcrsh, P.C.
5555 Metropolitan Parkway, Suite 200
Sterling Heights, MI 48310

Patient Acknowledgement and Consent Form

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

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed 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 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 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 acknowledge that 1 have today received a copy of the Notice of Privacy Practices.

______________________________ ____________________

Parent or Guardian Signature — Date — Patient Name (please print)

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement:

____

An emergency situation prevented the patent from signing the Acknowledgement.

____________________ ____________________

Office Personnel (signature) — Office Personnel (please print)

____

Date:

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.

______________________________ ____________________

Parent or Guardian Signature — Date — Patient Name (please print)