

**SACHS FAMILY DENTISTRY**  
**Patient Information**

DATE\_\_\_\_\_

TITLE\_\_\_\_\_NAME\_\_\_\_\_

ADDRESS\_\_\_\_\_

CITY\_\_\_\_\_ZIP\_\_\_\_\_

HOME PHONE\_\_\_\_\_CELL\_\_\_\_\_

E-MAIL\_\_\_\_\_

BIRTHDATE\_\_\_\_\_SSN and/or ID #\_\_\_\_\_

PLACE OF EMPLOYMENT\_\_\_\_\_

CITY\_\_\_\_\_ZIP\_\_\_\_\_WORK #\_\_\_\_\_

DENTAL INSURANCE\_\_\_\_\_GROUP #\_\_\_\_\_

REASON FOR THIS VISIT\_\_\_\_\_

REFERRED BY\_\_\_\_\_

**PERSON RESPONSIBLE FOR THE ACCOUNT**

NAME\_\_\_\_\_

ADDRESS\_\_\_\_\_

CITY\_\_\_\_\_ZIP\_\_\_\_\_PHONE#\_\_\_\_\_

DRIVERS LICENSE #\_\_\_\_\_EXPDATE\_\_\_\_\_

BIRTHDATE\_\_\_\_\_SOCIAL SECURITY#\_\_\_\_\_

PLACE OF EMPLOYMENT\_\_\_\_\_

CITY\_\_\_\_\_ZIP\_\_\_\_\_WORK#\_\_\_\_\_

DENTAL INSURANCE\_\_\_\_\_GROUP #\_\_\_\_\_

EMERGENCY PHONE#\_\_\_\_\_

# HEALTH QUESTIONNAIRE

Former Dentist:	_____
Phone:	_____
Family Physician:	_____
Phone:	_____
Pharmacy Name/Phone:	_____

Please answer all of the following questions by circling the best response.  
Your answers are for our records only and will be considered confidential.

- |   |     |    |
|---|-----|----|
| 1. Are you in good health?  | Yes | No |
| 2. Has there been any changes in your general health within the last year?                | Yes | No |
| 3. When was your last physical examination?   |     |    |
| 4. Are you being seen regularly by a physician for a disease or illness?                  | Yes | No |
| 5. Have you had any serious illness, operation, or been hospitalized in the last 5 years? | Yes | No |
| 6. Are you taking any medicine(s) including non prescription medicine?                    | Yes | No |
| a. List all medications that you are currently taking _____                               |     |    |

7. Have you ever taken weight loss medication?..... Yes No
8. Have you now, or in the past, ever had any of the following conditions?

**IF YES, PLEASE CIRCLE CONDITION THAT APPLIES TO YOU:**

- |  |     |    |
|--|-----|----|
| a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease.....   | Yes | No |
| b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis stroke)..... | Yes | No |
| • Do you ever have chest pains?.....   | Yes | No |
| • Are you ever short of breath after mild exercise or when lying down?   | Yes | No |
| • Do your ankles swell?.....   | Yes | No |
| • Heart defect or heart murmur?.....   | Yes | No |
| • Cardiac pacemaker?.....  | Yes | No |
| c. Sinus trouble.....  | Yes | No |
| d. Asthma or hay fever .....   | Yes | No |
| e. Fainting spells or seizures .....   | Yes | No |
| f. Persistent diarrhea or recent weight loss.....  | Yes | No |
| g. Diabetes or a family history of diabetes.....   | Yes | No |
| h. Hepatitis, jaundice, or liver disease.....  | Yes | No |
| i. AIDS or HIV infection.....  | Yes | No |
| j. Thyroid problems.....   | Yes | No |
| k. Respiratory problems, emphysema, bronchitis, etc.....   | Yes | No |
| l. Arthritis or painful swollen joints.....  | Yes | No |
| m. Stomach ulcer or hyperacidity .....   | Yes | No |
| n. Kidney trouble.....   | Yes | No |

**IF YES, PLEASE CIRCLE CONDITION THAT APPLIES TO YOU:**

- |   |     |    |
|---|-----|----|
| o. Tuberculosis.....  | Yes | No |
| p. Persistent cough or a cough that produces blood.....                           | Yes | No |
| q. Persistent swollen glands in neck.....   | Yes | No |
| r. Low blood pressure or high blood pressure.....                                 | Yes | No |
| s. Sexually transmitted disease, such as gonorrhea, syphilis, or herpes.....      | Yes | No |
| t. Epilepsy or other neurological disease.....                                    | Yes | No |
| u. Emotional problems.....  | Yes | No |
| v. Cancer.....  | Yes | No |
| w. Have you had abdominal or excessive bleeding? .....                            | Yes | No |
| x. Have you ever required a blood transfusion? .....                              | Yes | No |
| y. Do you have any blood disorder, such as anemia, leukemia, or sickle cell ..... | Yes | No |
| z. Have you ever had any treatment for a tumor or a growth? .....                 | Yes | No |
| aa. Artificial joint replacement.....   | Yes | No |
9. Are you allergic or have you had a reaction to:
- |  |     |    |
|--|-----|----|
| a. Penicillin or other antibiotics.....            | Yes | No |
| b. Sulfa drugs.....                                | Yes | No |
| c. Barbiturates, sedatives, or sleeping pills..... | Yes | No |
| d. Aspirin.....                                    | Yes | No |
| e. Iodine.....                                     | Yes | No |
| f. Codeine or other narcotics.....                 | Yes | No |
| g. Latex.....                                      | Yes | No |
| h. Other allergies (please list) _____             |     |    |
10. Do you smoke or use tobacco in any form?..... Yes No
11. Have you used heroin, cocaine, marijuana or any other such drugs?..... Yes No
12. Do you drink alcoholic beverages? .....
13. If you have any disease or problem not listed above, please explain below. \_\_\_\_\_
- 

**Women**

- |  |     |    |
|--|-----|----|
| 1. Are you pregnant?                   | Yes | No |
| 2. Are you nursing?                    | Yes | No |
| 3. Are you taking birth control pills? | Yes | No |

**Dental History**

- |   |     |    |
|---|-----|----|
| 1. Have you ever had any serious trouble associated with any previous dental treatment? | Yes | No |
| 2. Have you ever had an injury to your face, jaws, or teeth? .....                      | Yes | No |
| 3. When was your last dental visit? _____   |     |    |
| 4. Have you had any dental x-rays in the last 3 years? .....                            | Yes | No |
| 5. Have you ever received radiation treatment to your head or jaws? .....               | Yes | No |
| 6. Do you ever get cold sores or canker sores? .....                                    | Yes | No |
| 7. Do you ever feel that you have a dry mouth? .....                                    | Yes | No |
| 8. Does your jaw click or pop when you chew? .....                                      | Yes | No |

9. Does your jaw hurt when you chew? .....Yes No
10. Have you ever had a bad reaction to local anesthetics? .....Yes No
11. Are any of your teeth sensitive to sweets, hot, cold or biting? .....Yes No
12. Do any of your teeth feel loose? .....Yes No
13. Please check if you have received any of the following:
- a. gum/periodontal treatment.....Yes No
  - b. orthodontic treatment.....Yes No
  - c. root canal/ endodontic treatment.....Yes No
  - d. wisdom tooth removal.....Yes No
  - e. removal of other teeth.....Yes No
14. Are you wearing dentures or partial dentures? .....Yes No
- If so, were they made over 5 years ago? .....Yes No
15. Have you had teeth replaced with a fixed (cemented) bridge? .....Yes No
- If so, was the bridge made over 5 years ago? .....Yes No
16. Are you satisfied with the appearance of your teeth? .....Yes No
17. Do you wish you had more teeth to chew with? .....Yes No
18. Are you concerned about the cost of your dental treatment? .....Yes No
19. How do you feel about going to the dentist (circle the best answer)

NO PROBLEM

APPREHENSIVE

SCARED

**I certify that to the best of my knowledge the above information is complete and accurate.**

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

## CONSENT FOR DENTAL TREATMENT

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

\_\_\_\_\_  
\_\_\_\_\_

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

SIGNATURE (PATIENT OR GUARDIAN SIGNATURE)

\_\_\_\_\_

\_\_\_\_\_

Date

**SACHS FAMILY DENTISTRY**  
**\*\*Cancellation/No-Show Policy\*\***

We appreciate your business, but as you know, costs are rising and to avoid increasing charges, we must work together to keep expenses down. Therefore we consider any appointments made by patients confirmed when the patient makes the appointment. However, as a courtesy to our patients, we do make reminder calls.

If patients do not give us 24 hour notice for a cancellation, there will be a charge.

If you have any questions regarding this matter, please feel free to speak to the office manager.

Sincerely,  
DR. R. SACHS AND STAFF

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**WITH REGARDS TO INSURANCE PAYMENT TO OUR OFFICE**

**It is important that you be informed that our professional services are rendered and charged to you, not the insurance company. Our services are offered on the basis that any amount not paid by the insurance company is your responsibility.**

**When we call to verify your insurance coverage with your dental carrier it is never a guarantee of payment. We try our best to inform the patient of their actual co-payments in our office. However, it is just an estimated amount. We cannot guarantee that your insurance carrier will pay their percentage, each insurance carrier looks at claims on an individual basis. The insurance carrier for their own reasons may deny a claim. The patient may also have outstanding claims that were not processed at the time of our phone call to the insurance carrier which may cause the patient to owe more than we first anticipated. We try to obtain as much information from your dental carrier however; it is ultimately the patient's responsibility to know their insurance plan.**

**Regardless of insurance, the balance is ultimately the patients' responsibility.**

**Patient or responsible patient signature**

**Date**

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**\*\*REMINDER NOTICE\*\***

DUE TO THE MANY CHANGES IN INSURANCE POLICIES, IT IS NO LONGER AN EASY TASK TO INTERPRET EACH INDIVIDUAL POLICY. ALTHOUGH WE TRY TO STAY AWARE OF THESE CHANGES, IT IS NOT ALWAYS POSSIBLE. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE. WE EXPECT YOUR CO-PAYMENT AT THE TIME OF SERVICE AND WILL, IN MOST CASES, BE WILLING TO WAIT FOR THE REMAINING INSURANCE REIMBURSEMENT.

PLEASE REMEMBER: YOUR INSURANCE POLICY IS BETWEEN YOU AND YOUR INSURANCE COMPANY, NOT WITH THE INSURANCE COMPANY AND YOUR DOCTOR. YOU ARE ULTIMATELY RESPONSIBLE FOR THE PROFESSIONAL FEES, CO-PAYS, OR DEDUCTIBLES NOT COVERED BY YOUR INSURANCE. IF YOU HAVE SPECIFIC QUESTIONS, PLEASE CONTACT YOUR INSURANCE CARRIER OR OUR OFFICE MANAGER.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Sachs Family Dentistry  
3133 S. Telegraph Rd  
Dearborn, MI 48124  
313-565-6122

Thank you for choosing Sachs Family Dentistry. We take pride in offering competitive prices with out sacrificing excellent service. You can look forward to superior dental treatment and customer service. We offer a wide range of dental services. We have a website that we encourage you to visit <http://www.sachsdentistry.com>, which shows what services are offered here at Sachs Family Dentistry. Please do not hesitate to contact our office with any questions you may have before, during or after your visit.

We would also like to explain our financial policies prior to your initial visit. Please take a moment to review these policies. If you have any question regarding this document please feel free to discuss your concerns with our office team.

### Financial Policy

As a courtesy, Sachs Family Dentistry will bill all of your dental services to your primary/secondary dental carrier. The balance incurred from dental services will always remain your responsibility. Please be sure you review all Insurance statements as the come to your home. These statements will indicate what we have billed on your behalf, what your insurance company will or has paid and what your responsibility is. We will obtain a benefit statement prior to you initial visit. This statement will give an **estimate** of benefits for procedures completed by our clinical team.

Unfortunately, the insurance company will always have the right to determine benefits based on the criteria your employer has purchased on your behalf. It is our mission to provide the best dental care possible; we will never deliver treatment solely based on your insurance coverage.

We will do our best to inform you of coverage on dental procedures, however all expenses not covered by your insurance plan will be your responsibility.

All co-pays and deductibles must be paid as services are rendered, unless otherwise discussed with the office team.

All delinquent balances over 120 days will be sent to small claims court with 19<sup>th</sup> District Court. For this reason, it is very important you keep in contact with our office team if payments are not able to be made as initially contracted with our office.

Our office offers financing through various credit plans. The interest rate is most often less than average credit card interest. Please feel free to inquire with our staff regarding these offers. This is an excellent option to supplement your dental service balances in coordination with your insurance plan.

In efforts to keep our fees low, it is our policy that all appointments must be cancelled within 24 hours of the appointment time. Appointments not cancelled 24 hours in advance will be charged \$55.00 per missed appointment.

I understand and agree to all above Financial Policies.

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Patient/Guardian Signature

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Date