Dr. Daniel M. Sarya, DDS, MPH

REGISTRATION FORM

Today's date:	Patient Number (office use only):

PATIENT INFORMATION

Patient Last Name:	First Name:	Nickname:	M.I.	DOB:
Mailing Address:	Street Address:			
City:	State/Zip code:			
Home Phone:	Cell Phone:	Work Phone:		
Email address:	Social Security #:			
Dentist Name:				
Current Grade level:	Patient School:			
If patient is a minor, parent/guardian name:	If patient is a minor, are they adopted or a foster child?			
Whom may we thank for referring you:				
Family members seen here				

RESPONSIBLE PARTY & INSURANCE INFORMATION

(Please give your DENTAL insurance card to the receptionist)

1st Responsible Party Name:		Marital status: S M D W Sep
Relationship to patient:		
Mailing Address:	Street address:	Home ( )
City:	State/Zip code:	Work ( )
Social Security #:	Birthdate:	Cell ( )
Email address:	Email appt. reminders YES NO	Text appt. reminders YES NO
Occupation:		
Employer name & address:		Years employed:
DENTAL Insurance carrier/company:	Group #:	Contract/Policy #:
2nd Responsible Party Name:		Marital status: S M D W Sep
Relationship to patient:		
Mailing Address:	Street address:	Home ( )
City:	State/Zip code:	Work ( )
Social Security #:	Birthdate:	Cell ( )
Email address:	Email appt. reminders YES NO	Text appt. reminders YES NO
Occupation:		
Employer name & address:		Years employed:
DENTAL Insurance carrier/company:	Group #:	Contract/Policy #:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone ( )	Work/cell phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Dr. Daniel Sarya to perform orthodontic services and obtain any credit reports when necessary. I also authorize Dr. Daniel Sarya to release any information required to process my insurance claims.

_______________________________ *Patient/Guardian signature*

_______________________________ *Date*

Health & Dental History

Today's Date:

Name: *(Last, First, Middle)*	Nickname:	☐ M ☐ F	**DOB:**

Referring Dentist:	**Date of last Dental exam:**
Previous Orthodontic consultation? (Y or N)	**Height:** **Weight:**
Family Physician name & phone number:	**Mouth breather:** **(awake, asleep or both)**

PERSONAL HEALTH HISTORY

Illnesses/procedures performed (mark all that apply):

☐ Measles	☐ Mumps	☐ Pneumonia	☐ Speech problems	☐ Tonsils removed
☐ Rubella	☐ Chickenpox	☐ Hepatitis A/ B/ C	☐ Bleeding problems	☐ Adenoids removed
☐ Heart Condition	☐ Rheumatic Fever	☐ Epilepsy	☐ Scarlet fever	☐ Frequent colds
☐ Diabetes	☐ Polio	☐ Asthma	☐ Whooping cough	☐ Anxiety
☐ Anemia	☐ Nervous condition	☐ Tuberculosis	☐ Kidney problems	☐ ADHD
☐ Problems chewing	☐ Problems swallowing	☐ Breathing problems	☐ Fainting	☐ Other

Are Immunizations up to date?

Any discomfort when opening or closing mouth?

Are teeth brushed daily? How many times per day? **Is floss used?**

Positions while sleeping? (Side/back/face down/all)

Any past facial, mouth or teeth injuries?

Do you play any musical wind instrument?

Are you allergic to any metals?

List any medical or dental problems that other Doctors or Dentists have diagnosed:

Any surgeries & other hospitalizations? If yes, please explain:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

Office Use Only

Tongue Thrust: ☐ Frontal ☐ Lateral
Lip: ☐ Wedging ☐ Biting
Grinding: ☐ Awake ☐ Asleep ☐ Both
Posture: (Leaning on) ☐ Cheek ☐ Chin ☐ Nose ☐ Forehead

Sucking: ☐ Fingers ☐ Thumb ☐ Blanket ☐ Pacifier ☐ Cheek
Biting: ☐ Nails ☐ Pencils/Pens ☐ Other objects
Swallowing: ☐ Lips pursed ☐ Head nodding ☐ Unusual effort
Other observations:

Extractions needed:____________________________________

Fixed or removable treatment needed____________________

Phase I treatment fee:____________________________________

Phase II treatment fee:___________________________________

Complete treatment fee:__________________________________

Orthodontic office of
Dr. Daniel M. Sarya, DDS, MPH, PC
403 East State Street, Suite 200
Traverse City MI, 49686
(231) 947-7250

Privacy policy as it relates to you, our patient:

Our office has a privacy policy that indicates all patient information obtained in patient records is protected and will not be shared with any entity without the patient's permission. The exception to this rule is in processing insurance claims and working to coordinate treatment with another medical entity. While we are trying to help our patients in processing insurance, we will need to provide certain information to the insurance company (or its affiliates) in order to accurately process insurance claims. We may also need to share information with other medical entities in order to properly coordinate treatment plans. The entities with which we share information have indicated to us that they are also in full compliance of patient confidentiality laws and they, too, will not share any information provided to them.

No patient information will be sold, or distributed, to any other entity of any type without express permission from the patient, including transferring of materials from one orthodontic office to another or transferring of materials from our office to any other dental/medical related facility, unless it is necessary to provide this information in order to treat the patient for immediate dental/medical emergencies.

Any information provided to our office is obtained in full confidentiality and will remain protected as long as we are the "keeper" of those records. Public access is not acceptable or allowed.

Patients are able to obtain copies of data entered into their patient information provided they give reasonable notice to our office. Our office will provide material requested to an authorized person within 2 weeks after receiving the request for those materials from such an authorized person.

By signing this document you acknowledge that you have read and understand our privacy policy. This policy shall remain in force without further notice. Any change made to our privacy policy will be provided to you for acknowledgement.

Any questions relating to our privacy policy may be directed to our HIPAA coordinator, Shannon Vokes, by calling (231) 947-7250.

__________________________ _______________________________

Patient name — Patient signature or legal guardian if patient is a minor

Date:_______________________ ________________________________

Printed name of signature above