DATE

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

cell phone #

pager #

px & ex 2 in 12 cons

BWX allowed q 2 yr

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Dentistry For Northern Michigan PLLC

Eaglesoft Medical History-

Date .

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Who is your primary care physician? Name ____ Comment ____

What is your primary care physician's phone number? ____ Comment ____

Have you ever been hospitalized or had a major operation? Please List Dates ◯ Yes ◯ No If yes ____

Have you ever had a serious head or neck injury? Date - ◯ Yes ◯ No If yes ____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes ____

Do you use controlled substances? ◯ Yes ◯ No If yes ____

Do you use tobacco?

☐ 1/2 pack or less daily ☐ 1 pack daily ☐ More than one pack daily

Do you require an antibiotic premedication prior to dental treatments? ◯ Yes ◯ No If yes ____

Pharmacy Name and Phone Number- ◯ Yes ◯ No If yes ____

Are you taking any medications, pills, or drugs? List Below Detailed Medication List or attach- ◯ Yes ◯ No

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Dairy

Other? ☐ If yes ____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes ____

Comments:

Dental History

Who is your former dentist? ____ Comment ____

Do your gums bleed when you brush or floss? ◯ Yes ◯ No If yes ____

When was your last dental hygiene visit?

☐ 6 months- 1 year ☐ 2-5 years ☐ 5 or more years

Do you have any areas of concern in your mouth? ____

Do you drink soda or sports drinks often?

Daily ◯ Yes ◯ No

Weekly ◯ Yes ◯ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

DENTISTRY FOR NORTHERN MICHIGAN, PLLC
FAMILY, COSMETIC & SEDATION DENTISTRY
PAUL GUY STERNHAGEN, DDS, FAGD, FDOCS
DENTISTRYNM.COM, Info@DentistryNM.com
932 EAST EIGHTH STREET, TRAVERSE CITY, MI 49686, PHONE: 231-947-8586, FAX: 231-947-8115

Patient Name: _____ Date: _____

Smile Checklist

Y	N	Are you happy with your smile?
Y	N	Do you cover your mouth when you smile?
Y	N	Do you wish your teeth were straighter?
Y	N	Do you wish your teeth were whiter?
Y	N	Do you have any appliances in your mouth that are removable?
Y	N	Do you floss daily? How many times? _____
Y	N	Do you brush daily? How many times? _____
Y	N	Do you use any mouth rinses? If so, what kind? _____

What would you change about your smile if you could?

_____

_____

Facial Pain History

Y	N	Do you have pain in your face, neck, or shoulders?
Y	N	Do you have recurring tooth pain or sensitivity?
Y	N	Do you have ringing, fullness, or pain in your ears?
Y	N	Do you have difficulty opening your mouth/does your jaw get "stuck" or locked?
Y	N	Do your jaw joints make noises
Y	N	Do you have difficulty or pain with chewing, talking, or yawning?
Y	N	Do you have arthritis?
Y	N	Do you have difficulty swallowing?
Y	N	Have you had any previous treatment for your jaw joint problems?
		If so, when and by whom? _____

Don't Wait Until It Hurts

Periodontal disease is irreversible. It affects 87% of the population, and often victims are unaware. There are warning signs, and the American Dental Association and our Staff want you to be aware:

Y	N	Do your gums bleed when you brush your teeth or floss?
Y	N	Are your gums red, swollen, or tender?
Y	N	Are your gums pulling away from your teeth?
Y	N	Do you see pus between your teeth and gums when the gums are pressed?
Y	N	Are your permanent teeth loose or separating?
Y	N	Is there any change in the way your teeth fit together when you bite?
Y	N	Is there any change in the fit of your partial denture?
Y	N	Do you have bad breath?

If the answer is yes to any of these questions, you owe it to yourself to bring it to the attention of your dentist or hygienist. Act now to keep your teeth for a lifetime.

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AUTHORIZATION TO RELEASE PHI

PERSONAL HEALTH INFORMATION

I, _____, ACKNOWLEDGE THAT DENTISTRY FOR NORTHERN MICHIGAN, PLLC NOTICE OF PRIVACY PRACTICES HAS BEEN MADE AVAILABLE TO ME. I ALSO HEREBY AUTHORIZE DENTISTRY FOR NORTHERN MICHIGAN, PLLC TO RELEASE MY PROTECTED HEALTH INFORMATION TO THE PERSON(S) LISTED BELOW (EXAMPLE: SPOUSE, PARENT, GRANDPARENT, SIBLING, ETC.):

____ NO PERSON

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

THAT DENTISTRY FOR NORTHERN MICHIGAN, PLLC MAY LEAVE VOICEMAIL MESSAGES CONTAINING PROTECTED HEALTH INFORMATION AT THE FOLLOWING PHONE NUMBER(S) AND OR EMAIL ADDRESS:

____ NONE

_____
E-MAIL ADDRESS

AREA CODE	PHONE NUMBER	CIRCLE ONE: HOME/OFFICE/CELL
AREA CODE	PHONE NUMBER	CIRCLE ONE: HOME/OFFICE/CELL

_____ _____
SIGNATURE DATE

THIS AUTHORIZATION WILL EXPIRE WHEN MY HEALTH CARE THROUGH DENTISTRY FOR NORTHERN MICHIGAN, PLLC ENDS OR WHEN I REVOKE THIS AUTHORIZATION IN WRITING TO THE ABOVE LISTED ADDRESS.

DENTISTRY FOR NORTHERN MICHIGAN, PLLC
FAMILY, COSMETIC & SEDATION DENTISTRY
PAUL GUY STERNHAGEN, DDS, FAGD, FDOCS
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Consent to Dental Photography

I _____, give permission to Dentistry for Northern Michigan, to take photographs, and/or videos of my face, jaws and teeth before, during and after treatment.
I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Websites and printed materials, patient education, and social media

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.
I do NOT expect compensation, financial or otherwise, for the use of these photographs.

Patient Signature: _____ Date: _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Dr. Paul Sternhagen's "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Dr. Paul Sternhagen's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of users and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Dr. Paul Sternhagen. The Notice of Privacy Practices for Dr. Paul Sternhagen is provided on request at the main administration desk of this practice. The Notice of Privacy Practices also describes my rights and Dr. Paul Sternhagen's duties with respect to my protected health information.

Dr. Paul Sternhagen reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of the privacy practices by calling the office and requesting a revised copy, or asking for one at the time of my next appointment.

Patient's Name - Please print _____

_____ Date_____
Signature of Patient or Legal Guardian

_____
Relationship to the Patient

OFFICE USE ONLY
I attempted to obtain the patients signature in acknowledgment of this Notice of Privacy Practices, but was unable to do so as documented below:

_____ _____ _____
Date Reason Initials

DENTISTRY FOR NORTHERN MICHIGAN, PLLC
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone:_____Email:_____SS#:_____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practiced, we will issue a revised Noticed of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Dentistry For Northern Michigan, PLLC 932 E. Eighth Street, Traverse City, MI 49686 or by phone at (231)-947-8586

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treat you if you revoke this Consent.

Below: Please Print patient name and provide SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

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Philosophy of Care

I am proud to have served patients since 1985. My dental team and I are committed to our relationship-based practice. This commitment in combination with hundreds of hours of post-doctoral continuing education allows us to offer you and your family the highest quality of care and service that you are looking for.

The purpose of our practice is to advance the health of others through appropriate advice and care.

As your dentist, I can assure you that you will receive the personalized attention you deserve. We strongly believe in the value of the informed choice and feel that life-long dental health is only possible when the caregiver and the patient work together to achieve clearly defined goals, which they both feel are appropriate.

Comprehensive evaluations involve a gentle and careful review of the condition of the teeth, gums, muscle system, bite, TMJ's, previous dental work, and esthetics. They are intended to reveal only current needs, but also trends which may lead to fracture problems. Our patients value this accurate and timely information as it allows them the opportunity to make educated decisions and work collaboratively with us to achieve shared treatment goals.

Our Staff

Office Coordinators:	Help you in scheduling your appointments, answer any questions regarding our services or fees, and are here to assist you with any insurance questions or concerns.
Dental Assistants:	Helps in providing you with the best dental care. They are also available to assist you with any questions regarding your dental needs and concerns.
Dental Hygienist:	To not only to provide you with professional dental cleanings but also to offer oral hygiene aids and instruction to assist you in your dental home care.

Our Office Hours

Monday	8:30 AM	until	5:30 PM
Tuesday	8:30 AM	until	4:30 PM
Wednesday	8:30 AM	until	4:30 PM
Thursday	8:30 AM	until	4:30 PM

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PAYMENT OPTIONS AND CANCELLATION POLICY

Our team here at Dentistry for Northern Michigan is proud to have a primary mission to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top-quality care as cost-effective as possible.

Dr. Sternhagen is a participating Premier provider with Delta Dental. All other insurances for benefits, please verify you have "out of network benefits". Please provide us with your Insurance company Name, address, phone number, Id and Group numbers. The name, date of birth of insured with the employer name.

To assist you with your healthcare investment, we provide the 3 following payment options:

Cash – Including money orders and personal checks
Credit Cards- Visa, MasterCard, and Discover
Care Credit- Monthly payment plan

A Care Credit application is quick and easy and can be done online at carecredit.com. or by calling 800-365-8295. Care Credit is a great program we work with to allow you to make your dental needs a reality.

We value each one of our patient and reserve specific time for your appointments, but we do understand that life happens. We ask that you contact our office as soon as possible if you need to reschedule your appointment so we can give that time to another patient. Failure to keep your appointment(s) and/or cancel within a **2 day office schedule (Monday – Thursday)** advance notice is subject to office time fee, $55.00. Return Check, NSF, fee is subject to current bank rate plus hadling costs.

Please feel free to contact our office with any questions or concerns.

Thank You!

Dentistry For Northern Michigan, PLLC
Paul G. Sternhagen, DDS, FAGD, FDOC

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AUTHORIZATION FOR RELEASE OF DENTAL INFORMATION

I, _____(please print name of patient) authorize
Dr._____and
Dr. _____ to release the
following dental information to:

Dentistry For Northern Michigan, PLLC, Dr. Paul G. Sternhagen, DDS, FAGD, FDOCS.

_____
(Please provide Dental Office: name, phone and fax number, and email address).

_____
(Please provide Dental Office: name, phone and fax number, and email address).

For the following patient: _____DOB:_____

(Please initial below)

_____ Dental record (as of the date of this release); copies of last x-rays, periodontal charting, date of last hygiene listing eiher: Adult prophy/Periodontal Maintainence.
Please send x-rays in jpg format by email to Info@DentistryNM.com.

This information is being released for the following purpose(s) **only:**

And may not be used for any other purpose or released to any other person(s) without my written consent.

This release is effective for six months from the date of execution, however, it may be Revoked by me at any time by providing notice in writing to the above party.

Signaure: _____ _____
Patient/Patients/legal guardian of patient Date

S/_____
Witness