Drs. Amar Katranji, Kelly Misch and Julius Bunek welcome you to our office!

Our Financial Policy

The following describes our office financial policy. Our office is committed to providing you with the best possible care. **Your understanding of our financial policy is an essential element of your care and service.** If you have any questions regarding any aspect of our policy, please feel free to present your question to our team members. **Payment for services is due at the time that services are rendered.** We accept cash, debit card, and for your convenience, Visa, MasterCard, Discover and third party financing through Care Credit and Lending Club. ________initials

Our patients who have dental insurance are expected to pay the amount of their *estimated* co-pay and deductible at the time of service.

Insurance Policy and Assignment of Benefits (For patients with DENTAL insurance only)

As a courtesy, we will file the forms necessary to see that you receive the full benefits of your coverage. Because your insurance policy is a contract between you, your employer, and the insurance company, it is your responsibility to make sure we have accurate and up to date insurance carrier information, restrictions of your policy, and billing information. If your insurance company has not paid your claim in full within 60 days the remaining balance will automatically become patient responsibility. ________initials

Please be aware some and possibly all of the services provided many not be covered by your insurance provider. Services which are not covered, downgraded, or fall under L.E.A.T. (least expensive alternate treatment) by your insurance, are your responsibility. Any **balance left unpaid after 30 days** will be subject to a 4% finance charge. After 60 days the account may be considered for collection and the account will accrue a collection fee in addition to any past due balances. _________initials

Scheduling Policy

The time reserved with your doctor/hygienist is scheduled according to your specific needs, and is extremely important. If you are unable to make your reserved appointment time, please contact the office no later than 48 hours PRIOR to your scheduled appointment. We do understand that life happens, but any missed appointments without the 48 hour notice may be subject to a $50.00-$100.00 charge. Habitual missed appointments (2 within 6 months) may be grounds for dismissal from the practice. Please note, arriving 10 minutes late to a scheduled appointment may require your appointment to be rescheduled for a later date, and a charge may apply. We neither recognize nor enforce the terms of divorce or child support decrees. All minor patients must be accompanied by an adult (parent or legal guardian). The adult accompanying the minor is required to pay in accordance with our policies. ___________initials

A deposit of $100.00 is REQUIRED to schedule all surgical appointments. This will be applied to your treatment scheduled. Please allow 5 business days for rescheduling of this appointment with no charge. If less than 5 days is provided for rescheduling, the deposit may be considered for partial or non-credit reimbursement. ______initials

I have read and understand the Financial Policy and Scheduling Policy for Michigan Implants & Periodontics, PLC. I agree to abide by these policies. By signing this, I also authorize my primary and/ or secondary insurance company to make payments according to Michigan Implants& Periodontics, PLC as directed.

_______________________________________ ____________________

Signature of Patient/Responsible Party Date

____

Print Name

Patient Registration
PLEASE PRINT

Legal
Name________________________________Preferred____________________

Date of birth____________________**Social Security**________/______/________

Phone number (home/cell/work)______________ email_______________@________

Address:_______________________________________ APT_______

City:_________________________________State_______ Zip:______________

Emergency Contact ______________________Phone________________________

Preferred Pharmacy_____________________**Phone**_____________________

DENTAL insurance information:

Primary:

Policy Holder Name:______________________Date of Birth____________________

Employer______________________________Insurance Company_______________

Address:_______________________________Insurance Phone#_______________

Group or Policy #________________________ Contract ID/SS#_________________

Secondary:

Policy Holder Name:_______________________Date of Birth___________________

Employer:______________________________InsuranceCompany_______________

Address:_______________________________Insurance Phone#_______________

Group or Policy #_________________________Contract ID/SS#_________________

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ______

Name of Physician/and their specialty ______________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? ▢ Excellent ▢ Good ▢ Fair ▢ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury	▢	▢
2.	an allergic reaction to ▢ aspirin, ibuprofen, acetaminophen, codeine ▢ penicillin ▢ erythromycin ▢ tetracycline ▢ sulfa ▢ local anesthetic ▢ fluoride ▢ metals (nickel, gold, silver, ________) ▢ latex ▢ other ________		
3.	heart problems, or cardiac stent within the last six months	▢	▢
4.	history of infective endocarditis	▢	▢
5.	artificial heart valve, repaired heart defect (PFO)	▢	▢
6.	pacemaker or implantable defibrillator	▢	▢
7.	artificial prosthesis (heart valve or joints)	▢	▢
8.	rheumatic or scarlet fever	▢	▢
9.	high or low blood pressure	▢	▢
10.	a stroke (taking blood thinners)	▢	▢
11.	anemia or other blood disorder	▢	▢
12.	prolonged bleeding due to a slight cut (INR > 3.5)	▢	▢
13.	emphysema, sarcoidosis	▢	▢
14.	tuberculosis	▢	▢
15.	asthma	▢	▢
16.	breathing or sleep problems (i.e. snoring, sinus)	▢	▢
17.	kidney disease	▢	▢
18.	liver disease	▢	▢
19.	jaundice	▢	▢
20.	thyroid, parathyroid disease, or calcium deficiency	▢	▢
21.	hormone deficiency	▢	▢
22.	high cholesterol or taking statin drugs	▢	▢
23.	diabetes (HbA1c = ______)	▢	▢
24.	stomach or duodenal ulcer	▢	▢
25.	digestive disorders (i.e. gastric reflux)	▢	▢
26.	osteoporosis/osteopenia (i.e. taking bisphosphonates)	▢	▢
27.	arthritis	▢	▢
28.	glaucoma	▢	▢
29.	contact lenses	▢	▢
30.	head or neck injuries	▢	▢
31.	epilepsy, convulsions (seizures)	▢	▢
32.	neurologic problems (attention deficit disorder)	▢	▢
33.	viral infections and cold sores	▢	▢
34.	any lumps or swelling in the mouth	▢	▢
35.	hives, skin rash, hay fever	▢	▢
36.	STI / STD	▢	▢
37.	hepatitis (type ___)	▢	▢
38.	HIV / AIDS	▢	▢
39.	tumor, abnormal growth	▢	▢
40.	radiation therapy	▢	▢
41.	chemotherapy	▢	▢
42.	emotional problems	▢	▢
43.	psychiatric treatment	▢	▢
44.	antidepressant medication	▢	▢
45.	alcohol / street drug use	▢	▢

ARE YOU:

		YES	NO
46.	presently being treated for any other illness	▢	▢
47.	aware of a change in your health (i.e. fever, new cough)	▢	▢
48.	taking medication for weight management (i.e. fen-phen)	▢	▢
49.	taking dietary supplements	▢	▢
50.	often exhausted or fatigued	▢	▢
51.	experiencing frequent headaches	▢	▢
52.	a smoker, smoked previously or use smokeless tobacco	▢	▢
53.	considered a touchy person	▢	▢
54.	often unhappy or depressed	▢	▢
55.	FEMALE - taking birth control pills	▢	▢
56.	FEMALE - pregnant	▢	▢
57.	MALE - prostate disorders	▢	▢

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date __________

Doctor's Signature ______________________ Date __________

DENTAL HISTORY

Name________________________ Nickname________________________ Age_________

Referred by________________________ How would you rate the condition of your mouth? ▢ Excellent ▢ Good ▢ Fair ▢ Poor

Previous Dentist ________________________ How long have you been a patient?__________ Months/Years

Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______

Date of most recent treatment (other than a cleaning) ______/______/______

I routinely see my dentist every: ▢ 3 mo. ▢ 4 mo. ▢ 6 mo. ▢ 12 mo. ▢ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

#	Question	YES	NO
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]	▢	▢
2.	Have you had an unfavorable dental experience?	▢	▢
3.	Have you ever had complications from past dental treatment?	▢	▢
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	▢	▢
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted?	▢	▢
6.	Have you had any teeth removed?	▢	▢

SMILE CHARACTERISTICS

#	Question	YES	NO
7.	Is there anything about the appearance of your teeth that you would like to change?	▢	▢
8.	Have you ever whitened (bleached) your teeth?	▢	▢
9.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	▢	▢
10	Have you been disappointed with the appearance of previous dental work?	▢	▢

BITE AND JAW JOINT

#	Question	YES	NO
11.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	▢	▢
12.	Do you / would you have any problems chewing gum?	▢	▢
13.	Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods?	▢	▢
14.	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	▢	▢
15.	Are your teeth crowding or developing spaces?	▢	▢
16.	Do you have more than one bite and squeeze to make your teeth fit together?	▢	▢
17.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	▢	▢
18.	Do you clench your teeth in the daytime or make them sore?	▢	▢
19.	Do you have any problems with sleep or wake up with an awareness of your teeth?	▢	▢
20.	Do you wear or have you ever worn a bite appliance?	▢	▢

TOOTH STRUCTURE

#	Question	YES	NO
21.	Have you had any cavities within the past 3 years?	▢	▢
22.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	▢	▢
23.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	▢	▢
24.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	▢	▢
25.	Do you have grooves or notches on your teeth near the gum line?	▢	▢
26.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	▢	▢
27.	Do you frequently get food caught between any teeth?	▢	▢

GUM AND BONE

#	Question	YES	NO
28.	Do your gums bleed or are they painful when brushing or flossing?	▢	▢
29.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	▢	▢
30.	Have you ever noticed an unpleasant taste or odor in your mouth?	▢	▢
31.	Is there anyone with a history of periodontal disease in your family?	▢	▢
32.	Have you ever experienced gum recession?	▢	▢
33.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	▢	▢
34.	Have you experienced a burning sensation in your mouth?	▢	▢

Patient's Signature ________________________ Date ____________

Doctor's Signature ________________________ Date ____________

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MICHIGAN
IMPLANTS &
PERIODONTICS, PLC

Amar Katranji, D.D.S., M.S., P.C.
Kelly Misch, D.D.S., M.S., P.C.
Julius Bunek D.D.S, M.S., P.L.L.C.
Diplomates, American Board of Periodontology

Patient Consent for Use and Disclosure of Protected Health Information & Your Privacy Protection

Our office is fully committed to compliance with the HIPAA guidelines by providing appropriate security and privacy for our patient's records, providing our patients with proper access to their medical records and maintaining information and billing processes in compliance with national HIPAA standards.

I hereby give my consent for Michigan Implants & Periodontics, PLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Michigan Implants & Periodontics, PLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Michigan Implants & Periodontics, PLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tanya Poynter- Privacy Officer for Michigan Implants & Periodontics, PLC.

With this consent, Michigan Implants & Periodontics, PLC may call my home or other alternative location and leave a message on voicemail, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Michigan Implants & Periodontics, PLC may mail to my home or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Michigan Implants & Periodontics, PLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Michigan Implants & Periodontics, PLC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Michigan Implants & Periodontics, PLC may decline to provide treatment to me.

______________________________ ____________________
Signature of Patient or Legal Guardian Date

____
Print Patient's Name

760 W. Eisenhower Pkwy., Suite 120
Ann Arbor, MI 48103
www.miimplants.com

Tel (734) 975-1743
Fax (734) 975-1754
mi.implant@gmail.com

MICHIGAN IMPLANTS & PERIODONTICS, PLC

Amar Katranji, D.D.S., M.S., P.C.
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE POLICY

I acknowledge that I received a copy and read through the Notice of Privacy Practices for Michigan Implants & Periodontics, PLC.

Patient Name: ______________________________ Date: ____________________

Signature: ______________________________

I AUTHORIZE AND CONSENT THAT THE FOLLOWING INDIVIDUALS MAY BE INFORMED OF MY PERIODONTAL STATUS AND/OR TREATMENT RENDERED

I ______________________________, WILL ALLOW Michigan Implants & Periodontics, PLC to discuss my periodontal treatment or diagnosis with the following individuals listed below. An example would be a spouse or significant other, a family member, or friend who may be driving you home from treatment.

Name: ____________________________ Relationship: ____________________

Name: ____________________________ Relationship: ____________________

Name: ____________________________ Relationship: ____________________

Name: ____________________________ Relationship: ____________________

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