Ste 10 • 609 E Jolly Rd
Lansing, MI 48910

BECHTEL DENTISTRY
Jonathan J. Bechtel, D.D.S.
Comfortable, Comprehensive Family Dentistry

P) 517-882-7132
F) 517-882-6608

Welcome To Our Office

Our goal is to provide you comfortable, comprehensive and convenient dental care. We want to ensure that you have all your questions answered regarding your dental treatment. We are constantly striving to improve all aspects of the care that we provide for you. If you ever have a concern with any aspect of care, please contact me or one of our staff members so we may achieve our goal for you.

Patient Information

Name ☐ Mr. ☐ Mrs. ☐ Ms. _____
First *MI* *Last*

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What would you like us to call you? (preferred name) _____

Street Address _____

City _____ St _____ Zip _____

Phone #s Home _____ Work _____ Cell _____

E-mail Address _____

Social Security Number _____ Date of Birth _____

How would you like us to confirm your appointments?

☐ Mail ☐ E-mail ☐ Phone (☐ Home ☐ Work ☐ Cell) ☐ Text

Whom may we contact in case of emergency? _____

Phone _____

Whom may we thank for referring you? _____

Phone _____

Tell Us About You ...

The better we understand you, the better we can serve you. We don't like to make assumptions or guess about what makes you tick. Please place an ***X*** along each line indicating which way your opinion or preference leans.

I like to be presented with fewer options.		I like to be presented with more options.
I tend to look at the details.		I tend to look at the big picture.
I prefer long-lasting solutions that may cost more.		I prefer more short-term solutions at lower cost.
My insurance largely determines the extent of my care.		I largely determine the extent of my care.

(over please)

Primary Insurance and/or Person Responsible for Payment

Name ☐ Mr. ☐ Mrs. ☐ Ms. _____
First *MI* *Last*

Relationship to patient _____

If different from Patient Information:

Street Address _____

City _____ St _____ Zip _____

Phone #s Home _____ Work _____ Cell _____

Social Security Number _____ Date of Birth _____

Employer Name _____

Employer Address _____

Occupation _____

Insurance Company Name _____ Phone # _____

Group Number _____ Contract Number _____

Have you used your insurance this year? ☐ Yes ☐ No

Spouse and/or Secondary Insurance

Name ☐ Mr. ☐ Mrs. ☐ Ms. _____
First *MI* *Last*

Relationship to patient _____

Street Address _____

City _____ St _____ Zip _____

Phone #s Home _____ Work _____ Cell _____

Social Security Number _____ Date of Birth _____

Employer Name _____

Employer Address _____

Occupation _____

Insurance Company Name _____ Phone # _____

Group Number _____ Contract Number _____

Have you used your insurance this year? ☐ Yes ☐ No

To the best of my knowledge, the information above is correct. I realize that this office will provide insurance billing and assist with insurance benefits to the best of its knowledge. However, all charges for services and collection costs for untimely payments are ultimately my responsibility.

Signature (Parent's if minor) ***X*** _____ Date _____

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Medical History

Patient's Date of Birth _____

Today's Date _____

Name ☐ Mr. ☐ Mrs. ☐ Ms. _____
First *MI* *Last*

General Health: (Check Box) ☐ Excellent ☐ Good ☐ Fair Date of last physical _____

Physician's Name _____ Phone _____

Answers to the following are for our records and are confidential.

Are you under current medical treatment? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently taking any medications or herbal supplements? ☐ Yes ☐ No

If yes, please list all prescription and non-prescription medications, including vitamins and supplements, on Medication Log.

Do you have allergies or adverse reaction to drugs? ☐ Yes ☐ No

If yes, please list drug and reaction: _____

_____

Have you ever taken I.V. or oral Bisphosphonates for bone density such as Fosamax, Actonel, Boniva, Aredia, Zometa or Bonefos? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

Do you use any form of tobacco? ☐ Yes ☐ No

What Type (please circle) Cigarettes Cigars Snuff Chew How much? _____

Are you interested in quitting? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No If yes, how much per week on average? _____

Women, are you: (please circle) Pregnant Nursing On hormone therapy On birth control medication?

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

Rheumatic Fever	☐ yes	☐ no	Diabetes	☐ yes	☐ no
Respiratory Disease	☐ yes	☐ no	High Blood Pressure	☐ yes	☐ no
Heart Murmur	☐ yes	☐ no	Stroke	☐ yes	☐ no
Intestinal Disease	☐ yes	☐ no	Fainting Spells	☐ yes	☐ no
Heart Disease	☐ yes	☐ no	Epilepsy	☐ yes	☐ no
Other Heart Ailment	☐ yes	☐ no	Head Injuries	☐ yes	☐ no
Chemo/Radiation Therapy	☐ yes	☐ no	Caffeine Dependency	☐ yes	☐ no
Mitral Valve Prolapse	☐ yes	☐ no	Psychological/Psychiatric Treatment	☐ yes	☐ no
Cancer	☐ yes	☐ no	Bleeding Problems	☐ yes	☐ no
Artificial Joints	☐ yes	☐ no	Blood Transfusion	☐ yes	☐ no
Liver Disease	☐ yes	☐ no	Latex Sensitivity	☐ yes	☐ no
HIV or AIDS	☐ yes	☐ no	Organ Transplant	☐ yes	☐ no
Kidney Disease	☐ yes	☐ no	Have you been told you need Antibiotics prior to dental treatment?	☐ yes	☐ no
Venereal Disease	☐ yes	☐ no	Do you have a disease or condition not listed?	☐ yes	☐ no
Arthritis	☐ yes	☐ no			
Hepatitis	☐ yes	☐ no			
Major Operations	☐ yes	☐ no			
Pacemaker	☐ yes	☐ no			

If yes, please list: _____

_____

Dental History

What is your immediate dental concern?_____

Do you have dental pain now?_____

When was your last dental visit?_____

What was done at that appointment?_____

When: Was your last cleaning and exam?_____ Were your last dental x-rays taken?_____

Who was your previous dentist?_____ City_____ Phone_____

What influenced you to change dentists?_____

Are any of your teeth sensitive to hot or cold? ☐ Yes ☐ No Biting or chewing pain? ☐ Yes ☐ No

Please check if you have or have ever had:

- Unfavorable dental experiences ☐
- Dental fears ☐
- Preference for no dental anesthetic ☐
- Problems with effectiveness of or bad reactions to dental anesthetic ☐
- Orthodontic treatment (braces) ☐
  When?_____
- Bleeding gums ☐
- Habitual chewing of hard substances, ie: ice, popcorn kernels ☐
- Part of your mouth is sensitive to temperature ☐
- Lumps or bumps on head or neck ☐
- Dry mouth ☐
- Do you have a sugar or soda pop habit? ☐
- Unpleasant taste or odor in your mouth ☐
- Viral infection or cold sores ☐
- Jaw problems (TMJ) ☐
- Difficulty opening your mouth widely ☐
- Stiff or sore head, neck or shoulder muscles ☐
- Do you wake up with tooth or jaw pain? ☐
- Tension headaches ☐
- Clench or grind your teeth ☐
- Jaw clicking or popping ☐
- Any oral appliances ☐
- Any removable teeth ☐
- Family history of diabetes ☐
- Parents who have lost teeth or had gum disease ☐
- How often do you: Brush?_____ Floss?_____
- Other oral health aids: _____
- Noticed loose teeth or a change in your bite? ☐
- Breath through your mouth while awake or asleep? ☐

How important is it for you to keep your teeth for the rest of your life? (circle one)

Not Important 1 2 3 4 5 6 7 8 9 10 Very Important

How do you rank your smile? (circle one)

Unpleasant 1 2 3 4 5 6 7 8 9 10 Beautiful

What would you change about your smile or bite if you could?_____

_____

What is your biggest concern about having any dental treatment?_____

_____

To the best of my knowledge, the information above is correct. I realize that this office will provide insurance billing and assist with insurance benefits to the best of its knowledge. However, all charges for services and collection costs for untimely payments are ultimately my responsibility.

Signature (Parent's if minor) ***X***_____ Date_____

Medication Log

Patient Name _____ ☐ Medical Alert! _____

Date	Name of Medication	Prescribed For:	Dosage (how much, when & how often)
PLEASE INCLUDE ALL: PRESCRIPTION MEDICATIONS AND VITAMINS, HERBAL SUPPLEMENTS, ETC. ...			

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Medication Log

ACQUAINTANCE FORM

Jonathan Bechtel D.D.S.

Restoring Smiles, Preserving Faces

Date: _____

Patient Name: _____Single____Married____Widowed____Divorced____

Address: _____ City: _____

State: _____ Zip: _____ Social Security Number: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Birth date: _____

Employer: _____ Occupation: _____

Business Address: _____

Person Responsible for Account: _____

Do you have dental insurance? _____

How did you hear about Dr. Bechtel? _____

Whom may we thank for this referral? _____

These are things important to me about my dental health:

(Please Circle One)

1. My mouth is
   A.) very comfortable
   B.) moderately comfortable
   C.) uncomfortable

2. I (I am)
   A.) think the appearance of my mouth is excellent
   B.) satisfied with the appearance of my mouth
   C.) dissatisfied with the appearance of my mouth

3. I
   A.) will do anything to keep my natural teeth
   B.) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them
   C.) don't care whether I keep my teeth or not

4. I
   A.) have set goals for my oral health with a previous dentist
   B.) want to set goals concerning my dental health
   C.) never set goals concerning my dental health

5. I
   A.) have always done the best that was recommended for my dental health
   B.) have not done what dentists have recommended for my mouth
   C.) rarely go, and don't care much about having my dental work completed.

6. I have
   A.) put dentistry for myself and my family high on my priority list
   B.) put dentistry for myself and my family low on my priority list
   C.) it's on my list but hard to find

7. I think my present state of dental health is
   A.) excellent
   B.) good
   C.) poor

8. I aspire to a mouth with
   A.) excellent health
   B.) good health
   C.) poor health

9. What is/are your primary concerns?

_____

_____

_____

_____

_____

_____

_____

BECHTEL DENTISTRY
HEALTH-CENTERED ▪ WELLNESS FOCUSED ▪ DENTAL HEALTH COACHING
Jonathan J. Bechtel DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's

Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (please specify)

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Financial Policy

The primary goal of Bechtel Dentistry is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that all patients pay for their treatment, in full, on the day of each visit to our office; unless prior arrangements have been made.

We will do our best to provide an estimate of your investment in your dental health for each upcoming visit based on your individual treatment plan. We will also provide you with an estimate for your next upcoming visit(s) total bill. Please bring cash, check, or credit card at the time of treatment. With proper diagnosis and a timely treatment plan, most estimates are accurate; although an exact payment from your insurance cannot be known until the claim is processed.

Outstanding balances on your account are discouraged and must be cleared before the next appointment or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amounts due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month in addition to a $5.00 monthly billing fee per statement sent.

Delinquent balances over 90 days past due will be referred to an asset recovery agency. All referred accounts are marked "Inactive." In order to have your account reactivated and continue to receive treatment in our office, the delinquent balance must be paid in full to our office plus any fees associated with the collection of the delinquent account.

All returned checks will be charged an additional fee of $25.00; this fee will be added to your account balance. Before we accept another payment by check, the account balance plus the $25.00 fee must be paid in full by cash or credit card before another check will be accepted.

Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each patient and procedure. Missed appointments add to the cost of dental care when reserved facilities are left empty and not used. We respectfully request 48 hours advance notice for rescheduling your appointment. Your account may be charged a broken appointment fee of $100.00 for missed or broken appointments without proper notification.

You will need to bring your insurance card, coverage booklet, and a completed and signed dental insurance claim at your first visit, and at any time your insurance changes.

You need to be aware that:

- We will do our best to help you maximize your benefits.
- Although we file claims for you, your dental insurance policy is a contract between you, your employer, and your insurance company.
- Your treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.
- Our staff is trained to assist you with questions you may have relating to how your claim was filed, or regarding any additional information your carrier may need to process your claim.
- As a courtesy to all of our insured patients, we will file your dental insurance claim forms on your behalf. Most insurance companies will send the payment directly to our office; however, in special circumstances, a particular insurance company's benefit check may be sent to the patient's home. In such cases you are responsible at the time of treatment for payment in full; unless prior arrangements have been made.
- Your claim will be filed with your insurance company immediately and benefits are expected to be paid within 30 days. The filing of an insurance claim does not relieve you of a timely payment on your account. If the claim is not paid by your insurance company within 45 days, the unpaid portion will automatically become a "self pay" portion and added to your account with a statement for payment issued. You are responsible for any amounts your insurance company chooses not to pay for whatever reason. Any amounts expected to be paid by your insurance company, but not paid within 45 days become your responsibility, and if not paid in a timely fashion will begin to accumulate interest at a rate of 1.5% per month with a billing fee of $5.00 per monthly statement.

I understand and accept *the financial and dental insurance policies listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment in a timely fashion as described so as to avoid any additional fees.*

I further understand that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance company. I agree to pay such charges in full. Also, I hereby authorize release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Patient/Parent of Minor: _____ Staff Initials: _____Date_____

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Patient Consent

Publication of Records

I authorize Dr. Bechtel to take photos, videos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for treatment planning my case, the educational advancement of dentistry, and or insurance reimbursement purposes. By initialing below, I further consent to allow Dr. Bechtel to use my information for promotional purposes and understand that my identity will not be revealed to the public, however, without my authorization.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

_____

Date Printed Name and Signature of Patient, Parent, or Guardian

_____

Date Printed Name and Signature of Witness

_____

Date Printed Name and Signature of Doctor

_____ I Authorize Dr. Jonathan Bechtel to use my information for promotional purposes.
Initial

_____ I do not Authorize Dr. Jonathan Bechtel to use my information for promotional purposes.
Initial

_____ I Authorize Dr. Jonathan Bechtel to release my name to the public.
Initial

_____ I do not Authorize Dr. Jonathan Bechtel to release my name to the public.
Initial