DISTINCTIVE DENTAL

FAMILY · COSMETIC · IMPLANT

Welcome to Our Practice!

Dear New Patient,

We are pleased to welcome you to **Distinctive Dental**, where our mission is to make every visit comfortable, personal, and centered on you and your family's oral health.

As a privately owned **family dental office**, we truly enjoy caring for patients of all ages — from children experiencing their very first dental visit to adults looking to enhance their smile. Our team is dedicated to providing exceptional care in a warm, inviting environment where every patient is treated like family.

To help make your care as convenient and affordable as possible, we are **in network with most major dental insurance plans** (Delta Dental, MetLife, Cigna, Principal, and many others). This allows us to help you and your family receive high-quality care while maximizing your benefits and minimizing out-of-pocket costs.

Important: Please complete your **New Patient Packet** before your scheduled appointment time. You may either:

1. Print it out at home, fill it out, and bring it with you to your appointment
2. Use the link on our website to complete the forms online (for mobile users link is under "Contact Us" tab)
3. Arrive 15–20 minutes early to complete the forms in our office

Completing your paperwork ahead of time helps ensure your visit runs smoothly and on time.

Whether you're visiting us for a routine cleaning, restorative care, or a complete smile makeover, we're committed to providing gentle, modern, and personalized dentistry. We look forward to meeting you and building a lasting relationship!

Thank you for choosing **Distinctive Dental**— we're excited to welcome you and your family to ours!

Warm regards,

Dr. Alexander Hunt and the Team at Distinctive Dental

2120 Grand River Annex, Brighton, MI, 48114
(810) 225-0022
Distinctivedentalsmiles.com

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes ☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes ☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes ☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes ☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes ☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes ☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes ☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes ☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes ☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	How often do you floss? _____	
			Lip or cheek biting	☐ Yes	☐ No		
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____	

5 HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Do you wear contact lenses?	☐ Yes ☐ No				

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

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NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes how your health information may be used and shared, and how you can access it. Please read carefully.

Distinctive Dental is committed to protecting your privacy and is required by law to maintain the confidentiality of your health information. This notice explains how we use, share, and safeguard that information.

We may use and share your information to coordinate and provide your dental care, to process payments or insurance claims, and to manage office operations such as quality improvement, record keeping, and compliance with regulations. We may also share information when required by law or for reasons related to public health and safety. Distinctive Dental may change this notice as permitted by law, and any updates will be available in our office and on our website.

If you have any questions about your privacy rights you may contact our office at (810)-225-0022.

I acknowledge that I have received and reviewed a copy of this office's Notice of Privacy Practices (HIPAA).

Patient Name: _____

Signature: _____

Date: _____

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Insurance Disclaimer

Dental insurance is a valuable benefit that helps cover a portion of your treatment costs. However, please understand that insurance estimates provided by our office are not a guarantee of payment. Your dental plan is a contract between you, your employer, and your insurance company — not with our office. As a courtesy, we will submit claims and assist you in receiving your benefits, but any balance not covered by insurance is ultimately the patient's responsibility. Payment for services is due at the time they are provided unless other arrangements have been made in advance.

Your signature below acknowledges that you have read and understand the above statement, and all of your questions have been answered.

Patient Name: _____

Signature: _____

Date: _____