SCHOOL OF DENTISTRY
ORAL & MAXILLOFACIAL SURGERY/HOSPITAL DENTISTRY
UNIVERSITY OF MICHIGAN

Welcome to the Hospital Dentistry Clinic at Michigan Medicine. We are within Michigan Medicine at - 1500 E. Medical Center Dr., Floor 2 C213, Med Inn, Ann Arbor, MI 48109. and hope to form a partnership with the goal of helping you achieve the best possible oral health. Patient care is provided by faculty and residents, under the supervision of our well-trained and dedicated faculty.

The first visit will be a Tele-Health consultation in which we review the contents of the welcome packet, ask and answer additional questions, clarify processes and prepare for the first in-person visit. If the patient is not active on the Patient Portal, we would encourage this to be created for video visit capabilities. This is the best strategy for this visit. If Patient Portal access is impossible, we would then consider conducting the first Tele-Health visit via telephone.

To help us prepare, we request that you complete and return the following prior to scheduling your first Tele-Health visit.

- ✔ Patient Information/Medical and Dental Histories
- ✔ Social and Behavioral Intake Record

The Patient Information, Medical and Dental History along with Social and Behavioral Intake Record can be returned via Patient Portal, Secure Email address or US Mail - details listed below.

Return via Patient Portal - Secure Portal listed below
https://www.myuofmhealth.org/
Patient Portal Activation phone number: 734-615-0872

Return via Secure Email Address - Address listed below
HD-NewPatient@med.umich.edu

Return via US Mail - Address listed below
Michigan Medicine - Hospital Dentistry
1500 E. Medical Center Dr.
Floor 2, C-213 - Med Inn
Ann Arbor, MI 48109

Patients who are unable to make decisions about dental care for themselves must have an “alternate decision maker” or a health care representative, pursuant to Act 368 of 1978 in Michigan. Alternate decision makers may be a legal guardian, a health care agent (sometimes referred to as a “power of attorney” or POA) appointed by the patient, or other court-appointed decision maker. If there is an alternate decision maker, such as a legal guardian or medical power of attorney, the expectation is that he/she will be in the Hospital Dentistry Clinic during in-person visits and immediately available during all scheduled appointments for the patient. Alternate decision makers who cannot accompany patients can transfer their power to consent to another adult, as long as the proper documentation has been provided.

The Hospital Dentistry must know **IN ADVANCE** who can legally consent for the patient. The department must also be provided with documents necessary to prove authority to consent at all times.

While Hospital Dentistry will make every effort to contact an alternate decision maker, our providers will not perform procedures if we are unable to properly obtain informed consent from a legally-authorized individual.

- ✔ Supporting documentation for guardianship/POA
- ✔ Identification of alternate decision maker/guardian/POA

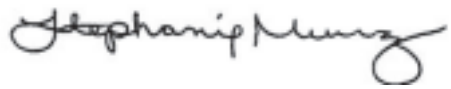
Please provide copies of the following if applicable:

- ✔ Patient Identification
- ✔ Patient Insurance Cards

If there is not enough room to provide detailed information, please attach separate sheets, as necessary.
All information will need to be returned prior to scheduling the first appointment. The prompt completion of this packet will facilitate scheduling the tele-health visit as soon as possible.

Thank you for choosing us to provide your dental care. We look forward to meeting you.

Kind Regards,



Stephanie Munz, DDS, FSCD
Clinical Associate Professor
Dr. Walter H. Swartz Endowed Professor of Integrated Special Care Dentistry
Associate Chair, Hospital Dentistry

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HOSPITAL DENTISTRY CLINIC

Patient Information
Medical and Dental History

Please print in black ink

Patient Information

Name:_____Preferred name:_____

Date of birth:_____

Address is:

- ⬜ Personal residence or family home
- ⬜ Group home
- ⬜ Intermediate or long term care facility
- ⬜ Other:_____

Gender identity:

⬜ Male ⬜ Female ⬜ Other:_____ ⬜ Prefer not to answer

General Information:

<u>Guardian/Alternate Decision Maker, if applicable</u>:

Name:_____
Relationship: _____
Contact phone number:_____

****Please provide supporting documentation authorizing authority to provide consent and make medical and dental decisions on the patient's behalf**

- ⬜ Not applicable - patient is able to consent for himself/herself

HOSPITAL DENTISTRY CLINIC

Primary care physician:

Name:_____

Address: _____

Phone:_____

Medical Specialist:

Name:_____

Specialty:_____

Address:_____

Phone:_____

**Please list any other medical specialists or providers on a separate sheet, if necessary

Preferred pharmacy:

Name:_____

Address:_____

Phone:_____

Current Medications (Please list all current medications, including over-the-counter medications. Attach additional pages if necessary)

Name and dosage	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies or Unusual Reactions:

Penicillin	Codeine	Latex	Aspirin	Local Anesthesia	Other_____ _____ _____

Type of reaction:_____

HOSPITAL DENTISTRY CLINIC

Check the symptom(s) and illness(s) or condition(s) that you currently HAVE or have HAD:

Respiratory:

O Yes O No O Unsure Asthma _____
O Yes O No O Unsure Bronchitis _____
O Yes O No O Unsure Emphysema _____
O Yes O No O Unsure Pneumonia _____
O Yes O No O Unsure Tuberculosis (TB) _____
O Yes O No O Unsure Sinus trouble _____
O Yes O No O Unsure Sleep apnea _____
O Yes O No O Unsure Tracheotomy/surgical airway _____
O Yes O No Other _____

Neurologic:

O Yes O No O Unsure Epilepsy/ Seizures (most recent, how often) _____
O Yes O No O Unsure Paralysis/ Weakness (circle one) _____
O Yes O No O Unsure Stroke _____Date of most recent _____
O Yes O No O Unsure TBI (traumatic brain injury) Date _____Details _____
O Yes O No O Unsure Shunt/type _____
O Yes O No O Unsure ALS _____
O Yes O No O Unsure Multiple Sclerosis _____
O Yes O No Other _____

Metabolic/ Hormonal:

O Yes O No O Unsure Diabetes Type I or Type II _____ Recent HbA1c?_____
O Yes O No O Unsure Thyroid problems _____
OYes ONo OUnsure Adrenal insufficiency_____
OYes O NoOUnsure Pituitary Problems _____
O Yes O No Other _____

Gastrointestinal:

O Yes O No O Unsure Acid reflux/ Heartburn _____
O Yes O No O Unsure Ulcer/ Gastritis _____
O Yes O No O Unsure Irritable bowel syndrome I Colitis _____
O Yes O No O Unsure Colostomy Bag, _____
O Yes O No O Unsure Eating Disorder _____
O Yes O No O Unsure Malnutrition/failure to thrive_____
O Yes O No O Unsure Feeding issues _____
O Yes O No O Unsure Tube fed ____ Oral intake? _____
O Yes O No Other _____

HOSPITAL DENTISTRY CLINIC

Major Organ Disease:
O Yes O No O Unsure Kidney disease _____
O Yes O No O Unsure Liver disease _____
O Yes O No O Unsure Spleen surgery _____
O Yes O No O Unsure Bladder disease _____ Catheter _____
O Yes O No O Unsure Organ transplant _____ When?_____
O Yes O No Other _____

Cancer or Neoplastic Disease:
O Yes O No O Unsure Cancer _____
O Yes O No O Unsure Leukemia/ Lymphoma _____
O Yes O No O Unsure Chemotherapy _____
O Yes O No O Unsure Radiation Treatment _____
O Yes O No Other _____

Cardiovascular:
O Yes O No O Unsure Limited activities for any reason _____
O Yes O No O Unsure Shortness of breath _____
O Yes O No O Unsure Heart murmur or irregular heart beat_____
O Yes O No O Unsure Mitral Valve Prolapse _____
O Yes O No O Unsure Artificial Heart Valve _____
O Yes O No O Unsure Heart disease/coronary artery disease_____
O Yes O No O Unsure Chest pain _____
O Yes O No O Unsure Congestive heart failure _____
O Yes O No O Unsure Heart attack_____
O Yes O No O Unsure High blood pressure _____
O Yes O No O Unsure Heart defects _____
O Yes O No O Unsure Other heart Problem_____

Hematologic/Blood
O Yes O No O Unsure Abnormal bleeding_____
O Yes O No O Unsure Anemia _____
O Yes O No O Unsure Blood transfusions (Date(s))_____
O Yes O No O Unsure Hemophilia or von Willebrand's disease _____
O Yes O No O Unsure Sickle Cell Anemia _____
O Yes O No Other_____

Immune system disorder:
O Yes O No O Unsure Autoimmune disease_____
O Yes O No O Unsure Rheumatoid arthritis_____
O Yes O No O Unsure Lupus_____
O Yes O No O Unsure Sjogren's syndrome_____
O Yes O No O Unsure HIV/AIDS _____
O Yes O No Other_____

HOSPITAL DENTISTRY CLINIC

Musculoskeletal disorder

O Yes O No O Unsure Spina bifida_____
O Yes O No O Unsure Scoliosis_____
O Yes O No O Unsure Osteoporosis/osteoarthritis _____
O Yes O No O Unsure Artificial Joint _____
O Yes O No O Unsure Muscular dystrophy _____
O Yes O No Other_____

Infectious Disease

O Yes O No O Unsure Rheumatic fever_____
O Yes O No O Unsure MRSA_____
O Yes O No O Unsure Sexually transmitted diseases _____
O Yes O No O Unsure Hepatitis _____
O Yes O No O Unsure COVID 19 _____
O Yes O No Other_____

Developmental Disabilities

O Yes O No O Unsure Down's syndrome_____
O Yes O No O Unsure Intellectual/cognitive disability_____
O Yes O No O Unsure Cerebral palsy _____
O Yes O No O Unsure Autism Spectrum Disorder _____
O Yes O No O Unsure ADD/ADHD _____
O Yes O No Other_____

Behavioral Conditions

O Yes O No O Unsure Aggressive behavior_____
O Yes O No O Unsure Anxiety/panic ttacks_____
O Yes O No O Unsure Dementia _____
O Yes O No O Unsure Alzheimer's _____
O Yes O No O Unsure Depression _____
O Yes O No Other_____

Other conditions

O Yes O No O Unsure Visual impairment_____
O Yes O No O Unsure Hearing impairment_____
O Yes O No O Unsure Chronic pain _____
O Yes O No O Unsure Frequent headaches _____
O Yes O No Other _____

Female patients

O Yes O No O Unsure Pregnant
_____
O Yes O No O Unsure Currently using birth control pills
_____
O Yes O No O Unsure Post-menopausal
_____

HOSPITAL DENTISTRY CLINIC

Dental History

What is the main reason for seeking dental care today? _____

When was the last dental visit: (Date) _____ O Unsure

Location of last dental visit _____

Please indicate the patient's most recent dental care, **within the past year** (check all that apply):

O Cleaning (Prophylaxis)
O X-Rays
O Fluoride Treatment
O Gum (Periodontal) Treatment
O Cavities / Fillings (Restorations)
O Root Canal (Endodontic) Treatment
O Crowns I Bridges (Prosthodontics)
O Dentures/ Partial Dentures (Prosthodontics)
O Implants
O Tooth Extractions
O Braces (Orthodontics)
O Treatment of Oral Infection(s)
O Adverse Reaction to Dental Treatment
O Other _____

Check the items that describe the patients dental care **in the last 5 years** (Check all that apply):

O Cleaning (Prophylaxis)
O X-Rays
O Fluoride Treatment
O Gum (Periodontal) Treatment
O Cavities/ Fillings (Restorations)
O Root Canal (Endodontic) Treatment
O Crowns/ Bridges (Prosthodontics)
O Dentures / Partial Dentures (Prosthodontics)
O Implants
O Tooth Extractions
O Braces (Orthodontics)
O Treatment of Oral Infection(s)
O Adverse Reaction to Dental Treatment
O Other _____

History of Oral or Facial Trauma/Injury? O Yes O No O Unsure

Describe _____

HOSPITAL DENTISTRY CLINIC

Has sedation ever been used for dental care? O Yes O No O Unsure

If yes, check all that apply:

O Nitrous Oxide (Laughing gas) O Oral sedation O IV (Intravenous) O GA (General Anesthesia) Please provide date and location of most recent sedation procedure: _____

Has physical restraint(s) (protective stabilization) ever been used to assist with patient management? O Yes O No O Unsure Describe _____

Do you think anesthesia / sedation will be necessary for dental treatment?

O Yes O No O Unsure Describe _____

Print name of person completing questionnaire:_____

Signature: _____

Relationship to patient:_____

Date: _____

HOSPITAL DENTISTRY CLINIC

Social and Behavioral Intake Record

General Information:

Speech: O Verbal O Impaired O Non-verbal
Hearing: O Normal O Impaired O Deaf
Vision: O Normal O Impaired O Blind

Primary Language:_____

Would an interpreter be helpful? O Yes O No Language or ASL? _____
Is a communication device used?..... O Yes O No Describe _____
Patient understands simple commands ..... O Yes O No O Unsure
Overall Communication Skills ..... O Effective O Fair O Poor

Able to walk without assistance? ..... .O Yes O No O Unsure
Wheel Chair ..... .O Yes O No O Unsure
Walker ..... .O Yes O No O Unsure
Crutches/Braces ..... .O Yes O No O Unsure
Able to be transferred to dental chair?.....O Yes O No O Unsure
Requires assistance to dental chair .. .. .O Yes O No O Unsure
Needs physical support in dental chair .....O Yes O No O Unsure
Glasses ..... .O Yes O No O Unsure
Hearing Aid(s) ..... .O Yes O No O Unsure
Dentures ..... …..... .O Yes O No O Unsure
Arm contractures ..... .O Yes O No O Unsure
Leg contractures ..... .O Yes O No O Unsure

Self-Abusive Behavior (SIB)

O Yes O No O Unsure
If yes. describe _____

Approaches that work best with the patient:

O Calm (Passive) O Direct (Rules/Limits) O Humor O Reward O Other_____

Describe what relaxes or calms the patient: _____

Patient likes to be rewarded with:

O Verbal Praise O Prizes _____ O Food _____ O Other _____

HOSPITAL DENTISTRY CLINIC

Patient's experience with dental care may be helped with:

Touch: O Soft O Medium O Firm O Limited touch
Sound: O Low O Medium O Loud
Lighting: O Soft O Normal

Dental Provider Preference:

O No preference O Male O Female O Other _____

Guest Preference:

O Family Member _____ O Staff Member/Caregiver _____ O Other _____

Item: O Toy O Blanket O Music O Other _____

Please provide any additional information that you feel would be helpful while meeting and treating the patient.
(For example: best time of the day for appointment, favorite topic of conversation,
chair position, previous positive experiences, etc.)

_____
_____
_____
_____
_____

CONSENT FOR TREATMENT
Is the patient able to consent for his/her own treatment?
O Yes O No

If NO, who is the patient's Alternate Decision Maker who will be available to give consent during the appointment?

Name:_____ Relationship: _____

****Attach supporting documentation of legal guardianship or health care agent/power of attorney.**

SCHOOL OF DENTISTRY
UNIVERSITY OF MICHIGAN

Patient Registration Information – Please Print using black or blue ink

Title	Patient's Last Name	First Name	Middle	Preferred	Gender

Date of Birth	Social Security No.	Marital Status	Email Address

Home Address	Apt or Box No.	City	State	Zip Code

Home Phone Number _____ Daytime Phone Number _____ Cell Phone Number _____

Preferred Method of Contact:
Text me at ( ) _____ Send me an email at _____@_____ Call me at ( ) _____

Emergency Contact – Name Relation Daytime Phone No. Address (Street, City, State, Zip)

Race/Ethnicity (optional)
Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐

Hispanic / Latin / Spanish Yes ☐ No ☐

Guardian Information

Title	Last Name	First Name	Middle	Relation	Gender

Date of Birth	Social Security No.	Marital Status		

Home Address	Apt or Box No.	City	State	Zip Code	Email Address

Home Phone Number Daytime Phone Number Cell Phone Number Preferred Contact Number

Patient's Primary Dental Insurance Information

Subscriber's Name	Subscriber's ID	Subscriber's DOB	Insurance Co.	Group No.

Employer	Address of Employer	Subscriber's Relationship to Patient

Patient's Secondary Dental Insurance Information

Subscriber's Name	Subscriber's ID	Subscriber's DOB	Insurance Co.	Group No.

Employer	Address of Employer	Subscriber's Relationship to Patient

Assignment of Benefits and Release of Information

I authorize the University of Michigan School of Dentistry (UMSD) or the Dental Faculty Associates (DFA) to release any and all information contained in my dental/ medical records to (a) any third party payer, insurance agencies or carriers or their agents which may be responsible in whole or in part for paying any expenses associated with my treatment; (b) any health care facility or provider for the purpose of facilitation continuing care and treatment; (c) attorneys or agencies representing the UMSD or the DFA in connection with collection actions against insurers, benefit plan, or the patient, or estate; and (d) any federal or state agency as required by law.

I assign and authorize direct payment of all health care benefits and other forms of payment of any kind which relate to the care provided to me at the UMSD, the DFA or its offsite clinics for application to my bill(s). I assign to the UMSD or the DFA all claims benefits or any related rights or claims I may have under the Employment Retirement Income Security Act (ERISA) or other applicable law, against any insurer, employee, trustee, fiduciary, employee welfare plan, employee benefit association, or other person who may be liable to pay charges due to the UMSD or the DFA for my care, and agree that the UMSD or the DFA may pursue any claim to these benefits, whether or not I choose to pursue that claim. I guarantee full financial responsibility for payment of all expenses associated with my care and treatment, including any portion of any charges not paid by insurance, including motor vehicle insurance, worker's compensation or social agencies and agree to pay the same at the time of delivery of service, discharge from treatment, or on any interim basis. These expenses will include but are not limited to deductibles, co-insurance, non-covered benefits services, and services requiring prior authorization which were not authorized

_____ _____ _____
Signature of Patient, Parent, or Guardian Date **Relationship to Patient**

_____ _____
Witness Signature Date

Revised 9/2019

Welcome to the Hospital Dentistry Clinic, located at 1500 E. Medical Center Dr, Floor 2 C213, Med Inn, Arbor, MI 48109 .

Plan ahead for traffic disruptions and construction. We encourage you to arrive about 30 minutes before your appointment to ensure you have ample time for parking and commuting to your appointment. Questions regarding parking, please visit www.uofmhealth.org/patient.

When you come for your visit to the Hospital Dentistry you will need to bring the following items:

1. **Current photo ID** (ie, Driver's License, Passport, School ID, etc)
2. **Insurance Cards** (Dental and Medical)

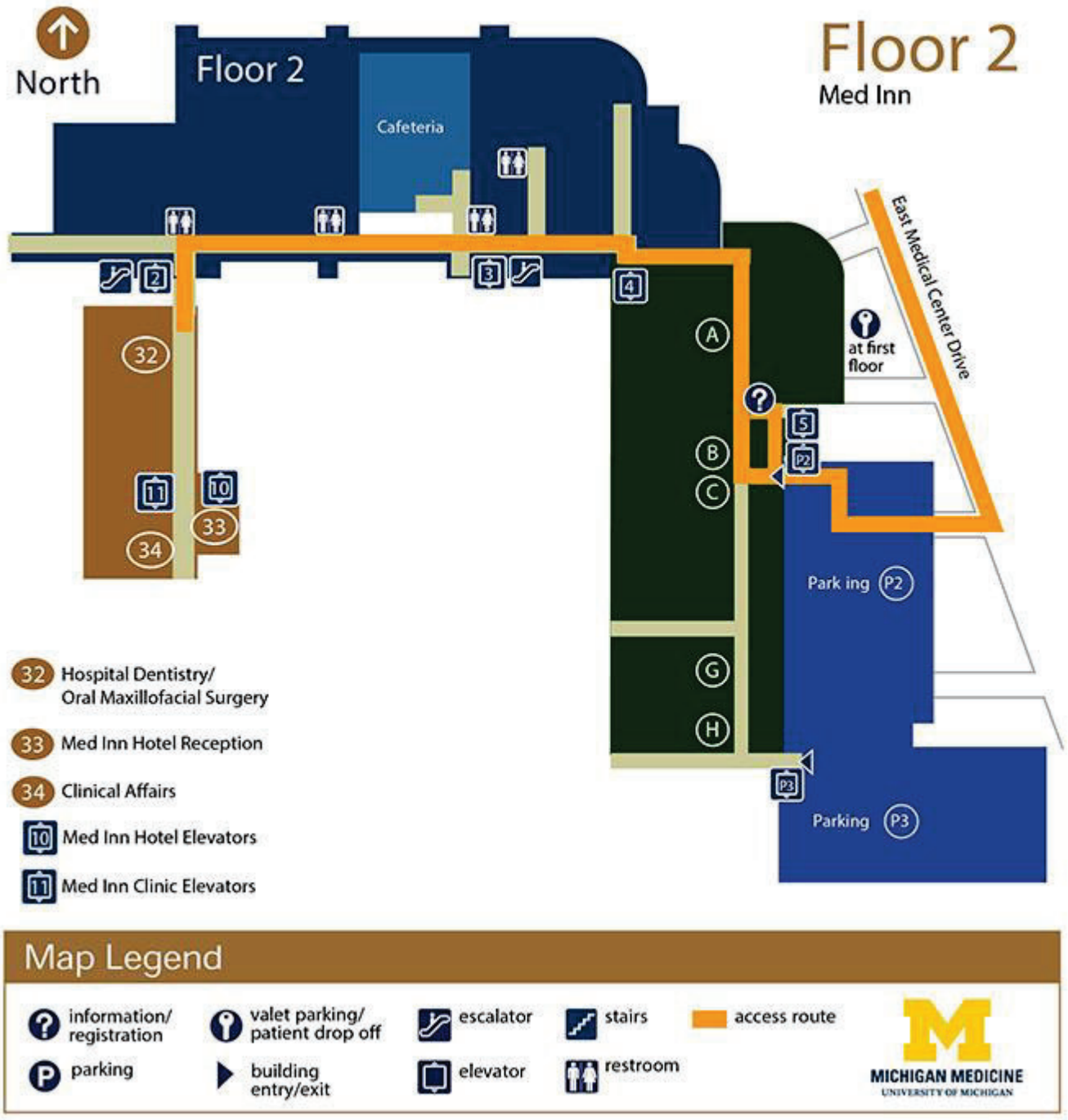
If you have existing X-rays please send them to: **HD-NewPatient@med.umich.edu**

We appreciate your interest in Hospital Dentistry. We look forward to seeing you.

Patient Information:

Patient Parking Structure P2 address: 1500 E. Hospital Dr, Ann Arbor, Michigan 48109-1078

Med Inn - Floor 2



Directions to Floor 2 Med Inn Building

Parking for Med Inn is in **Parking Structure P2**. Remember the level on which you parked. If you will be visiting for more than 4 hours, bring your **parking coupon** with you to your appointment to be validated at the information desks for a reduced rate.

Take the parking structure elevator **P2 to Floor 2.** Turn right after exiting the elevator and enter the Taubman Center, passing the Information Desk and taking the corridor to your right.

When the corridor ends, turn left. Enter University Hospital and follow the main corridor left, until you see the courtyard on your left. Continue along the courtyard and turn leftt into the 1st hallway. **You are now in the Med Inn Building**.

*Detailed directions to services located on Floor 2 of the Med Inn Building are listed below. Look for signage to assist you in finding your location.

The Med Inn Hotel Lobby and Registration Desk are located on the left of the hallway coming from University Hospital, adjacent to Elevator 10. For reservations call (800) 544-8684.

Hospital Dentistry (http://www.uofmhealth.org/our-locations/oral-maxillofacial-surgeryhospital-dentistry-clinic-med-inn) / **Oral & Maxillofacial Surgery** (http://www.uofmhealth.org/our-locations/oral-maxillofacial-surgeryhospital-dentistry-clinic-med-inn) The check-in desk is located on your right, just before Elevator 11

DIRECTORY

BUILDINGS

PATIENT & VISITOR PARKING

P1 Cancer Center only **D4**
P2 & P3 University Hospital, Taubman Center, & Med Inn . . . **E7 & F7**
P4 Mott Children's Hospital & Von Voigtlander Women's Hospital **G6**
P5 Cardiovascular Center only (underground parking). **F5**

STREETS

MORE MAPS

including floor maps for major buildings:
www.uofmhealth.org/maps

CONNECT WITH US ON SOCIAL MEDIA

www.uofmhealth.org/umhs-social-media

CALL OUR OPERATORS

734-936-4000

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HEALTH SYSTEM
UNIVERSITY OF MICHIGAN

PATIENT/VISITOR MAP & GUIDE

www.UofMHealth.org