

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY STATE ZIPBIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHERMINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED**INSURANCE INFORMATION****PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY**

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Has any member of your family ever been treated in our office?

 Yes NoWhom may we thank for referring you to our office?
_____**METHOD OF PAYMENT**

Responsible party currently has an account with this office

 Yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (VISA MC OTHER)

Card # _____ Exp. Date _____

 I wish to discuss the Dental Office's Financial Policy**AUTHORIZATION**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

Date _____ State Driver's License # _____

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of \$_____ for a balance under \$_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

PATIENT INFORMATION

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
 Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk Other _____
Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.
Table with 4 columns of conditions and Yes/No checkboxes.

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____
History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.
Table with columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, PULSE, REVIEWED BY.

HIPPA Form

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Grove Street Dental Care to use and disclose my protected health information to:

- **Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.**
- **To carry out the day-to-day healthcare operations of your practice.**
- **Conduct normal health care operations such as quality assessment and improvement activities.**
- **Obtain payment from third-party payers for my health care services.**

Notifications:

- **I have also been informed of, and given the rights to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.**
- **I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these request restrictions.**
- **However, if you do agree, you are bound to comply with this restriction. I understand that I may revoke this consent at any time, in writing, signed by you.**

The Patient understands that:

- **We will not release information to any future doctor, attorney, life insurance company, or workman's company without your written consent.**
- **Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare operations within our office.**
- **The practice reserves the right to change the notice of privacy practices.**
- **The patient has the right to restrict the use of their information, but the practice does not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality health care.**
- **The patient may revoke this consent in writing at any time and all future disclosures will then cease.**

The practice may condition treatment upon the execution of this consent (for example, you may be required to pay your visit at the time of service)

Print Name: _____

Relation to Patient: Self/Parent/Guardian

Signature: _____

Date: _____