GrandValleyDentistry

Something to Smile About

WELCOME! If you are a new patient to our practice, we would like to welcome you. If you are an established patient, we want to thank you for the trust you have placed in our practice for your dental care. We look forward to providing all of our patients with the most modern dental care available. Our office can provide you with complete general dental services ranging from preventative and fillings, to full mouth reconstruction and cosmetic dentistry.

Name____ Preferred Name______________________

First *MI* *Last*

Address____ DOB _______________ Gender/Pronouns ___________

City____ State__________ Zip_____________ SS # ______________________________

E-Mail ____ Cell # _________________________ Home # __________________________

Employer____ Work # ____________________ EXT______

Emergency Contact Name ______________________________________ Phone # _________________ Relationship __________________

RESPONSIBLE PARTY *(If different than patient info)*

Name____

First *MI* *Last*

Address____ City_______________ State ________ Zip ___________

Relationship to Patient ________________________________ Cell # _______________________ Home # __________________________

DOB _________________ Employer____________________________ Work# _____________

DENTAL INSURANCE

Subscriber's Name_______________________________________ DOB___________ Relationship to Patient _______________________

Subscriber's Social Security #____________________ Employer ______________________Insurance Company_______________________

Policy #___________________________ Group # _____________________________ ID #______________________________________

Whom or what may we thank for referring you? ____

MEDICAL AND DENTAL HISTORY

Patient Name:

CHECK BOX IF YOU HAVE EVER HAD OR HAVE TAKEN ANY OF THE FOLLOWING:

☐ ADD/ADHD
☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina *type*______
☐ Anxiety *current* Y/N
☐ Arthritis/Gout
☐ Artificial Joint(s)
*type & year*_______________
☐ Artificial Heart Valve
*year*________
☐ Asthma
☐ Blood Disease
☐ Blood Thinners
☐ Blood Transfusion ________
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer *type & year*___________
☐ Chemotherapy *year*________
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder

☐ Convulsions
last episode _______
☐ Cortisone Medicine
☐ Depression *current* Y/N
☐ Diabetes *type*_______
☐ Drug Addition *current* Y/N
☐ Eating disorder *current* Y/N
☐ Easily Winded
☐ Emphysema
☐ Epilepsy/Seizures
last episode _____
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Headaches
☐ Genital Herpes
☐ GERD
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
*year*_______
☐ Heart Murmur
☐ Heart Pacemaker
*year*________

☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Hypo Salivary Meds
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia *year*________
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
*year*______
☐ Recent Weight Loss

☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Sjorgens Syndrome
☐ Spinal Bifida
☐ Stomach/Intestinal Disease
☐ Stroke year______
☐ Swelling of Limbs
☐ Tobacco Products
☐ Thyroid Disease
☐ Tonsilitis
☐ Tuberculosis *year*_____
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice
☐ Other/Unlisted __________
____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Local Anesthetics Other: _________________

Have you been hospitalized or had major surgeries in the last 10 years? ☐ Yes ☐ No ____

Do you take any blood thinners? ☐ Yes ☐ No __________________ Do you use tobacco? ☐ Yes ☐ No ________________

ARE YOU: ☐ *Pregnant? weeks:* _________ ☐ *Trying to get pregnant?* ☐ *Taking oral contraceptives?* ☐ *Nursing?*

List all medications, supplements and/or vitamins that you're currently taking:

Name_____________________________________ Purpose____

Name_____________________________________ Purpose____

Name_____________________________________ Purpose____

PREVIOUS DENTIST'S NAME: ____ Phone# ____________________

PRIMARY PHYSICIAN'S NAME: ____ Phone# ___________________

PREFERRED PHARMACY (Name & Location): ____

Signature____Date_______________________________

Consent and Acknowledgment of Policies Patient Name:

RELEASE OF INFORMATION

Please print clearly any person(s) you authorize the release of information regarding your personal patient file under our HIPPA privacy policy. **Scheduling appointments on your behalf, asking billing or account questions, and discussing treatments options all require this section to be completed**.

I, ____ authorize the following person(s) to have access to information covered under the HIPAA Privacy Practice regarding myself;

____ *(Printed name and relationship)*

____ *(Printed name and relationship)*

____ *(Printed name and relationship)*

____ *(Printed name and relationship*

The required signatures below pertain to the policies provided in the protective sleeve attached to your clipboard. Please read each policy carefully before signing. You may request a copy of all policies at the front desk.

CONSENT TO DIAGNOSE AND TREAT

By signing below, I hereby authorize Grand Valley Dentistry to take any X-rays deemed necessary for diagnosis and to perform any type of treatment deemed appropriate. I acknowledge that further consent for certain procedures will require further consent.

HIPAA PRIVACY POLICY AND PATIENT CONFIDENTIALITY

By signing below, I am stating that I have received a copy of this office's Notice of Privacy Practices. This is the acknowledgment receipt of Grand Valley Dentistry's HIPAA Privacy Policy or to document their good faith effort to obtain this acknowledgment.

CANCELLING OR RESCHEDULING APPOINTMENTS

By signing below, I am stating that I have read and acknowledge Grand Valley Dentistry's cancellation policy. I understand that a 24-hour notice is required to cancel or reschedule all appointments and a $50 fee will be assessed if I fail to give proper notice.

PATIENT COORESPONDANCE

By signing below, I am stating that I have read and agree to Grand Valley Dentistry sending me phone call, text, and email communications.

INSURANCE, PAYMENTS, AND ACCOUNT BALANCES

By signing below, I am stating that I have read and acknowledge Grand Valley Dentistry's policies regarding insurance, copays, payments, overdue balances, and services charges.

____

(Printed Name) *(Signature)* (*Date)*

Office Policies

Consent to Diagnose and Treat: By signing Grand Valley Dentistry's Consent and Diagnose to Treat, you hereby authorize Grand Valley Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the signed patient's dental condition and needs. You authorize Grand Valley Dentistry to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Grand Valley Dentistry choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to use as deemed appropriate by Grand Valley Dentistry. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

Patient confidentiality: Our office follows the federal "HIPAA" Health Insurance Portability and Accountability Act, and Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. We do not sell your personal or medical information to anyone. We do not share your information with anyone other than your insurance carrier, pharmacist, or other dental specialist. We keep all your information confidential. We have enclosed a copy of our policy. By signing our form, you are acknowledging receiving notice of our practices' policies and rights regarding PHI. You allow release of pertinent medical records to my insurance company (if any applicable) and other medical providers.

Cancelling or Rescheduling Appointments: For your convenience the office is open Monday through Friday. We provide each patient with appropriate time based on the procedure and needs of the patient. This is to ensure a relaxed and comfortable environment for your dental needs. If an appointment cannot be kept, we ask for 24-hour notice. **A missed appointment fee of $50 will be assessed if we do not have at least 24-hour notice.** We try to keep appointments at their scheduled times, we ask that you try to do the same.

Patient correspondence: We offer email and text messaging auto messaging for appointment reminders and alerts. You authorize Grand Valley Dentistry to contact you with reminders, questions, or general information about changes in our practice or updates in office policies.

Insurance, Payments, and Account Balances: We will be glad to submit any insurance claims. By signing, you authorize Grand Valley Dentistry to verify insurance coverage, if any, to submit claims and provide your insurance company with information required for a claim, to assign benefits payable to them, and to handle any necessary claim appeal(s) on your behalf. While our dental team will be glad to help you with your coverage, it is important that you are familiar with your plan. All policies differ in payment schedule, deductibles, annual maximus, allowable fees, etc. Please keep in mind you are responsible for your total obligation should your insurance co deny a claim, delay payment, or if benefits are less than anticipated. We are happy to file the necessary forms to see that you receive the full benefits of your coverage. **We cannot guarantee any estimated coverage.** Your unpaid deductible and any estimated portion of fees not covered by your insurance are due at the time of service. Because the insurance policy is an agreement between you and the insurance company, and you are directly responsible for all charges. If for any reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time. **Full payment is required at the time of service from all patients that do not have insurance coverage.** If your balance has not been paid by your insurance company within 60 days, you are responsible for paying that balance. All unpaid balances are subject to a 1.5% monthly service charge. Any delinquent account will be required to pay all past due balances in full before incurring any new charges. All future charges will need to be paid at the time services are rendered. Severely delinquent accounts will be assigned to a collection agency.

Payment Options:

- **CASH or CHECK:** For fees exceeding $200.00 per patient, we are happy to offer and 5% courtesy adjustment for all treatments paid at the time of service. This excludes orthodontic care, and a $35 service fee will be charged for any bounced checks.
- **CREDIT CARDS:** For your convenience, we have made arrangements to accept payment by Mastercard, Visa, Flex Spending, HSA, and Care Credit.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects pf running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. IN the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards, text messages, phone calls, emails. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials and/or report suspected abuse, neglect, or domestic violence.

Any uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations or based on your previous operations.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of 4/1/2013, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formally, written complaint with us at the address below, or with the department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information abut our Privacy Practices, please contact:

Jessica Aten
5916 Lake Michigan Drive
Allendale, Michigan 49401
616-895-7400