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 Prefix

Address_____ Marital Status_____ Male____Female____

City_____ State_____ Zip_____ Home# (___)_____ EXT_____

Employer_____ Work# (___)_____ EXT_____

DOB____/____/_____ SS#_____ E-Mail _____@_____ Cell# (___)_____ EXT_____

Spouse's Name_____
First MI Last

Spouse's Occupation_____ Work# (___)_____ EXT_____

Is Patient a Full Time Student? Yes___No___ Name of School_____

RESPONSIBLE PARTY (If different than patient)

Name_____
First MI Last

Address_____ Relationship_____

City_____ State_____ Zip_____ Home# (___)_____

Employer_____ Work# (___)_____

DOB____/____/____ SS#_____ Mobile# (___)_____

DENTAL INSURANCE

Subscriber's Name_____ DOB ____/____/_____

Insurance Carrier_____

ID#_____ SS #_____

Group#_____ Policy #_____

Address_____ Phone #_____

ADDITIONAL DENTAL INSURANCE

Subscriber's Name_____ Relationship to Patient_____

DOB____/____/____ Subscriber's SS#_____ Insurance Company_____

Policy #_____ Group#_____ ID#_____

MEDICAL INSURANCE

Subscriber's Name_____ Relationship to Patient_____

DOB____/____/_____ Subscriber's SS#_____ Insurance Company_____

Policy #_____ Group#_____ ID#_____

YOUR PREFERENCE'S

Prefer appointment reminders by: E-Mail___ Phone___ Text___ Prefer to receive calls at: Home___ Work___ Cell___

Whom may we thank for referring you?_____

MEDICAL HISTORY/ALLERGIES

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

__AIDS/HIV positive
__Alzheimer's Disease
__Anaphylaxis
__Anemia
__Angina
__Arthritis/Gout
__Artificial Heart Valve
Date_____
__Asthma
__Blood Disease
__Blood Transfusion
__Breathing Problem
__Bruise Easily
__Cancer Type_____
__Chemotherapy
__Chest Pains
__Cold Sores/Fever Blisters
__Congenital Heart Disorder
__Convulsions
__Cortisone Medicine
__Diabetes
__Drug Addiction
__Eating Disorder
__ Easily Winded
__ Emphysema
__Epilepsy or Seizures
__Excessive Bleeding
__Excessive Thirst
__Fainting Spells/Dizziness
__Frequent Cough
__Frequent Headaches
__Genital Herpes
__GERD
__Glaucoma
__Hay Fever
__Heart Attack/Failure
__Heart Murmur
__Heart Pacemaker
__Heart Trouble/Disease
__Hemophilia
__ Hepatitis A
__Hepatitis B or C
__Herpes
__High Blood Pressure
__Hives or Rash
__Hypoglycemia
__Hypo Salivary Meds
__Irregular Heartbeat
__ Kidney Problems
__Leukemia
__Liver Disease
__Low Blood Pressure
__Lung Disease
__Mitral Valve Prolapse
__Pain in Jaw Joints
__Parathyroid Disease
__Psychiatric Care
__Radiation Treatments
__Recent Weight Loss
__Renal Dialysis
__Rheumatic Fever
__Rheumatism
__Scarlet Fever
__Shingles
__Sickle Cell Disease
__Sinus Trouble
__Sjorgens Syndrome
__Spinal Bifida
__Stomach/Intestinal Disease
__Stroke
__Swelling Of Limbs
__Thyroid Disease
__Tonsillitis
__Tuberculosis
__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_____

Are you under a Physician's care now? __Yes, Please explain_____

Have you ever been hospitalized or had a major surgeries? __Yes, Please explain_____
(within the last 10 years)

Do you have any artificial joint(s)? __Yes, Please explain_____

Do you use or have you used tobacco? __Yes, Please explain_____

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

Name_____ Purpose_____

Name_____ Purpose_____

Name_____ Purpose_____

Primary Physician's Name_____Phone# (___)_____Last Visit Date_____

FOR WOMEN

__ Pregnant/Trying to get pregnant __ Taking oral contraceptives __ Nursing

Signature_____Date_____

HEALTH AND WELLNESS FORM

Patient Name **Date**

ABOUT YOUR DENTAL EXPERIENCE

What brings you to the dentist today?___

Are you currently experiencing any dental pain? __Yes __No When was your last dental appointment?_____

How often do you brush per day? 0 1 2 3 4 or More How often do you floss per day? 0 1 2 3 4 or More

How many times a day do you snack between meals? Minimal / 1-3Times / 3+ Times

How much soda or Acidic Beverages do you drink per day? None / 1-3 / 3+ Beverage_____

Do you have any of the following?
__Fluoridated Water __Fluoridated Toothpaste __Fluoride Mouth Rinse __Xylitol Gum/Mints

If you could change your smile, you would:
(Please check all that apply)

__ Have a brighter, whiter smile
__Make your teeth straighter/ close spaces between teeth
__Replace silver metal fillings with tooth colored fillings
__Replace old crowns that don't match
__Healthier gums
__Fresher Breath

On a scale from 1 to 5, with 5 being the highest rating:
(Please circle the number that best applies)

How important is your dental health to you? 1 2 3 4 5

How would you rate your current dental health? 1 2 3 4 5

Has your doctor told you that you require antibiotics before dental treatment? __yes __No

Do your gums ever bleed? __yes __No

Have you ever had a serious/difficult problem associated with any dental work? __yes __No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? __yes __No

Do you have any of the following?
__Dentures __Partial Dentures __Periodontal (gum) Treatment __ Implants __Bite Guard

Grand Valley Dentistry
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Appointment/Cancellations: For your convenience the office is open Monday thru 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 48 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.

Insurance: As a courtesy, we will be glad to submit any insurance claims. 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 for 60 days, or if benefits are less than anticipated.

General consent to diagnose and treat: The undersigned hereby authorizes Grand Valley Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I 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.

Financial Consent: I understand that responsibility for payment of services provided in the office for myself or my dependent(s) is mine, due and payable at the time services are rendered. I understand that I'm responsible for any portion of fees for services rendered not covered by my dental of medical insurance (if any). I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Grand Valley Dentistry and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to him, and to handle any necessary claim appeal(s) on my behalf.

Consent (Adult)_____ **Date**_____

Signature of Patient

Consent (for minor Child):

Name of Parent/Guardian _____ **Date** _____

Signature of Parent/Guardian

Patient confidentiality: Our office follows the federal "HIPPA" 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 below you are acknowledging receiving notice of our practices' policies and rights regarding PHI. I allow release of pertinent medical records to my insurance company (if any applicable) and other medical providers.

_____ **Date**_____

Signature of Patient

Patient correspondence: We offer email and text messaging alerts. By signing this you are agreeing to allow us to send you a welcome text that you may choose to opt in.

_____ **Date**_____

Signature of Patient

ACKNOWLEDGEMENT OF RECIEPT OF

NOTICE OF PRIVACY PRACTICE

Purpose: This form is used to obtain acknowledgment of receipt of our notice of Privacy Practice or to document our good faith effort to obtain that acknowledgment.

You may refuse to sign this acknowledgment

I _____ have received a copy of this office's Notice of Privacy Practices.
Print name:_____
Sign: _____
Date:_____

Authorization to Release Information
Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.
I, _____authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____
(Please print name) Relationship

_____
(Please print name) Relationship

_____
(Please print name) Relationship

For office use only
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
__Individual refused to sign
__Communication barriers prohibited obtaining the acknowledgment
__An emergency situation prevented us from obtaining acknowledgment
__Other (please specify)_____