New Patient Registration

Welcome to Groves Dental Care!

How did you hear about us? _____

Name: _____ DOB: _____/_____/_____ Age: _____ Gender: Male / Female

Is there a preferred name or nickname you would like us to call you? YES/NO _____

Marital Status: _____ Spouse name: _____ Spouse Phone#: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Email: _____

Home Phone#: (_____)_____-_____Cell Phone#: (_____) _____-_____Work Phone#: (_____) _____-_____

SSN#: _____ Drivers License#: _____ State: _____

*If married, is your emergency contact your spouse? YES/NO
If No, please provide the information below, or add an additional one if necessary.

Emergency contact: _____ Phone # :(_____) _____-_____ Relation: _____ _____

Primary Care Physician: _____ Phone #: (_____) _____-_____ last visit: _____

DENTAL HISTORY

How may we help you today? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Have you had any new major stress recently (new job, moving, relationships)? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

Are you apprehensive about dental treatment? ☐ Yes ☐ No

Do you avoid chewing and/or brushing any part of your mouth due to pain? ☐ Yes ☐ No

Do you have any jaw symptoms or headaches upon waking up in the morning? ☐ Yes ☐ No

Are you aware of any broken teeth or teeth with cavities? ☐ Yes ☐ No

How often do you brush? _____ How often do you floss? _____

Who was your previous Dentist: _____ Phone#: (_____) _____-_____

When was your last dental cleaning? _____ When was your last dental visit? _____

Why did you leave your previous dentist? _____

MEDICAL HISTORY

*Please Note; If you have a medication list, please bring it up with your paperwork so we can make a copy of it.

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No
If so, for what? _____

Do you use tobacco in any form? ☐ Yes ☐ No

Are you **currently** taking blood thinners? ☐ Yes ☐ No If so, which one? _____

Have you **EVER** taken any oral or IV Bisphosphonate drugs (To treat Osteoporosis)? ☐ Yes ☐ No
(Examples: Fosamax, Zometa, Actonel, Boniva, Aredia, Reclast, Binosto)

Conditions

Yes	No		Yes	No	
❑	❑	Abnormal bleeding	❑	❑	Glaucoma
❑	❑	Alcohol abuse	❑	❑	HIV+ AIDS
❑	❑	Anemia	❑	❑	Heart Attack
❑	❑	Angina Pectoris	❑	❑	Heart Murmur
❑	❑	Arthritis	❑	❑	Heart Surgery
❑	❑	Artificial heart valve	❑	❑	Hemophilia
❑	❑	Asthma	❑	❑	Hepatitis B
❑	❑	Cancer	❑	❑	Hepatitis C
❑	❑	Chemotherapy	❑	❑	High Blood Pressure
❑	❑	Congenital heart defect	❑	❑	Joint Replacement
❑	❑	Diabetes	❑	❑	Kidney Problems
❑	❑	Difficulty breathing	❑	❑	Liver Disease
❑	❑	Drug Abuse	❑	❑	Low Blood Pressure
❑	❑	Emphysema	❑	❑	Mitral valve prolapse
❑	❑	Epilepsy	❑	❑	Acid reflux
❑	❑	Fainting Spells	❑	❑	Psychiatric problems
❑	❑	Frequent Headaches	❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever	❑	❑	Seizures
❑	❑	Sexually Transmitted Disease	❑	❑	Shingles
❑	❑	Sickle cell disease	❑	❑	Sinus problems
❑	❑	Stroke	❑	❑	Thyroid problems
❑	❑	Tuberculosis	❑	❑	Ulcers

Allergies

	Yes	No
Local anesthetics (“Novocaine”)	❑	❑
Penicillin or other antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates, Sedatives, or sleeping pills	❑	❑
Aspirin, Acetaminophen, or Ibuprofen	❑	❑
Codeine, Demerol, or other narcotics	❑	❑
Reaction to metals	❑	❑
Latex or rubber dam	❑	❑

Other Allergies: _____

Women

	Yes	No
Are you taking contraceptive or other hormones?	❑	❑
Are you pregnant?	❑	❑

If so, what is your due date? _____
Are you currently nursing?

List any medications you are currently taking and the dosage

_____
_____
_____
_____

Print Name: _____

Patient Signature: _____ Date: _____

Financial Policy and Dental Benefits

Thank you for choosing our office for your dental needs! We are committed to providing you with excellent dental care and an amazing overall patient experience. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and desire in order to enjoy a healthy and beautiful smile with respect to your budget.

In order for this to occur, we ask for your understanding of our financial policy:

Payment for services is due at the same time services are provided unless other payment arrangements have been agreed upon in advance. We accept cash, debit cards, credit cards, and cashier's checks/money orders. Personal checks may be accepted, but treatment cannot be rendered until the check has cleared. Also, we provide financing options offered through Care Credit and Lending Club. These financing options even offer some no-interest payment plans!

A down payment of 20% (of the total out-of pocket cost of treatment) is required in order to reserve your chair for the appropriate amount of time needed to complete your care.

If you have dental benefits, we will help you receive your maximum allowable benefits. We are more than happy to discuss any proposed treatment with you in addition to answering any questions you may have regarding your dental benefit plan. Please understand that:

1. Your dental benefits are based upon a contract made between yourself or your employer and an insurance company**. We are NOT involved in that contract. For the most part, dental benefits plans will never pay for completion of your dental care. It is only meant to assist you.**
2. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. While we gladly file your insurance claims as an added courtesy, you, as the patient are ULTIMATELY responsible for all charges from the date of service rendered, including any charges the insurance company may not have reimbursed us for, even though services were rendered.
3. Not all services are covered benefits. We will always try and help you receive your maximum allowable benefits, but sometimes the treatment a patient really needs is not a covered benefit. We strive for excellence and maintaining the most ethical standard possible. Therefore, some situations may not allow us to use a portion of your benefits due to the fact that it would greatly compromise your care.

Broken appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice. No cancellation fee will be assessed for a broken appointment, but we do reserve the right not to see you for future appointments if this occurs more than once. We simply just ask you to be mindful by giving us at least a 24 hour notice if you need to reschedule or cancel an appointment. This notice may provide another patient, who may desperately need to be seen, the opportunity to utilize that reserved chair.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our team members.

I have read, understand and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at **Groves Dental Care.**

Patient name (Printed)**: _____**

Patient Signature: _____ Date: _____

Groves Dental Care

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 IT.

I. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

II. Last Revision Date

This Notice was last revised on January 20th, 2017.

III. How We May Use or Disclose Your Health Information Permitted By Law (This is not meant to be an exhaustive or all-inclusive list)

A. Common Uses and Disclosures: Treatment, Payment from health plan, Health Care Operations, Appointment Reminders via phone, cell, text, or message. Disclosure to Family Members and Friends who are involved in your care or payment of care**,** and, Disclosure to Business Associates**.**

B. Less Common Uses and Disclosures: Disclosures Required by Law, Public Health Activities, Victims of Abuse, Neglect or Domestic Violence, Health Oversight Activities, Lawsuits and Legal Actions, Law Enforcement Purposes, Coroners, Medical Examiners and Funeral Directors.Organ, Eye and Tissue Donation, Serious Threat to Health or Safety, Workers' Compensation.

We must obtain written authorization from you if we use your health information for any other reason/s

IV. Your Rights with Respect to Your Health Information: Right to Access and Review, Right to Amend, Right to Restrict Use and Disclosure, Right to Confidential Communications, Alternative Means and Location, Right to an Accounting of Disclosures (for 6 years prior to the date that accounting is requested)**,** Right to a Paper Copy of this Notice, Right to Receive Notification of a Security Breach, Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information**,** Our Right to Change Our Privacy Practices and This Notice, and How to Make Privacy Complaints.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

Patient name (Printed): _____

Patient Signature: _____ **Date:** _____

Privacy Practices Acknowledgement

Acknowledgement of Receipt

I _____ acknowledge that I have received a copy of Groves Dental Care's Privacy Practices.

Patient Name (Printed): _____ Date: _____

Patient Signature: _____

GROVES DENTAL CARE

Please fill out this form so we can better understand any esthetic concerns you may have!

Please **RATE YOUR SMILE** on a scale from 1 to 10 with 1 being very unsatisfied and 10 being extremely satisfied:

1 2 3 4 5 6 7 8 9 10

If you rated your smile anywhere from 1 to 9, please tell us what you would change if you could:

- Alignment (crooked teeth)
- Discoloration
- Missing teeth
- Spaces (gaps)
- Small teeth
- Large teeth
- Chips or fractures

Other: _____

If you did NOT rate your smile a 10, would you like to have options that will give you the smile you have always wanted?

Yes or No

(Circle one)