ABOUT YOU

Todays date:_____

Name: _____

I prefer to be called: _____

SS#: _____

Birthdate: _____ Age:_____

Male Female

Home Address _____

_

Cell #:_____

Email Address:_____

May we leave a message or text for scheduling? Y N

Employer:_____

Occupation:_____

Single Married Divorced Widowed Separated

Emergency contact:
Name: _____ Relation: _____

Wk #: _____ Cell #: _____

INSURANCE COVERAGE

Primary

Dental Coverage Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation:_____

Insured's ID #: _____ Insured's B-Day: _____

Insured's Employer_____

Secondary

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation:_____

Insured's ID #: _____ Insured's B-Day: _____

Insured's Employer_____

I certify that I, and/or my dependent(s), have insurance coverage listed above and assign directly to Grand Corner Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that Grand Corner Dental will bill my insurance on my behalf, and that all treatment plan models are an ESTIMATE and not a guarantee of insurance coverage.

_____
Signature Date

I understand that payment is due at time of treatment unless prior arrangements have been approved.

_____ _____
Signature Date

How would you rate your oral health on a scale 1-10?
Where would you like to be?

How much do you love your smile esthetics on a scale of 1-10?
Where would you like to be?

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

Are you interested in sedation for dental procedures?

Medical History

Physician's name _____

Phone #_____. Date last visit_____

Your current physical health? Good. Fair Poor

Please List medications you are taking or provide a list.

Have you ever taken Fosamax or other bisphosphonates? Y or N

Ever had radiation to head or neck?: Y or N

For Women Are you pregnant ____ Week #

Are you nursing?

Have you ever had any of the following medical problems?

- o Abnormal bleeding
- o Alcohol / Drug abuse
- o Anemia
- o Arthritis
- o Artificial Bones/Joints Valves
- o Asthma
- o Blood Transfusion
- o Cancer / Chemo Tx
- o Congenital Heart Defect
- o Developmental Delay
- o Diabetes
  - o Type 1. 2
  - o A1C #
- o Emphysema
- o Epilepsy
- o Frequent headaches
- o Glaucoma
- o Heart Attack
  - o Date
- o Heart Murmur
- o Heart Surgery
  - o Date
- o Hemophilia
- o Herpes / Fever Blisters
- o High Blood Pressure
- o HIV / AIDS
- o Hospitalized
- o Kidney Problems
- o Liver Problems
- o Low Blood Pressure
- o Mitral Valve Prolapse
- o Pacemaker
- o Psychiatric care
- o Radiation Tx
- o Rheumatic / Scarlet Fever
- o Seizers
- o Sensory Issues
- o Shingles
- o Sickle Cell Trait
- o Stroke
- o Thyroid Problems
- o Tuberculosis (TB)
- o Ulcers
- o Venereal Disease

Any other serious medical conditions?

_____

Are you allergic to any of the following?

Amoxicillin / Penicillin	Hydrocodone
Clindamycin	Ibuprofen
Dental Anesthetics	Latex
Jewelry	Metals

Dental History

Why have you come to the Dentist today?

Do you require antibiotics before dental treatment? Yes No

Do you have sensitivity with your teeth?

Sweets. Cold. Heat, Biting, Other.

Where?
Duration?

Do your gums ever bleed? Yes No

Do you now or have you ever had pain in your jaw joint? Yes No

How often do you: floss?
brush?

Do you smoke or use any tobacco/marijuana products?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature Date

----INTERNAL USE----

I verbally reviewed the medical and dental history and information with he patient names herein.

Initials Date

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Financial Policy

Thank you for choosing Grand Corner Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable as possible.

_____**Initial** Payment is due at time of service. For your convenience we accept Cash, Check, Visa, MasterCard, or American Express. If for any reason your account is not paid in full, it is subject to 12% APR after 30 days.

_____**Initial** All treatment plans are an estimate based on the information we have obtained from your insurance company. Actual amount due may be different from your treatment cost estimate.

No-interest payments are available through Care Credit upon approval. This allows you to pay monthly payments over 6 months with no annual fees or prepayment penalties.

As a courtesy to you, we will bill most insurance companies. I authorize payment of my insurance benefits directly to Grand Corner Dental. I understand that Grand Corner Dental will make every effort to collect payment from my health insurance company; However, I understand that regardless of my account status, I am ultimately responsible for all charges incurred for services rendered at Grand Corner Dental to the extent of the law.

I am responsible for notifying Grand Corner Dental of any changes in my Billing Address, Phone Number and Health Insurance Information.

_____**Initial** Appointment Change Policy: To avoid a $75.00 charge, you must give 48 business hours' notice for all appointment changes.

_____**Initial** Grand Corner Dental will charge $100.00 for returned checks.

If you have any questions, please do not hesitate to ask. It is a pleasure to assist you in meeting your dental needs.

_____ _____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ Phone Number: _____

Patient Address: _____

I authorize Grand Corner Dental to release information identifying me (Including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released: Information relating to patient's treatment, appointments, and account
2. To whom may the information be released: Patient's insurance carrier, Patient's spouse, Patient's Parents. Additional Persons: _____
3. The purpose(s) for the release: Patient scheduling, treatment and payment for services. Additional Purposes: _____
4. Expiration date or event relating to the individual or purpose for the release: Open ended unless expiration date entered: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information he/she wishes. Sometimes, state or federal changes this possibility.

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

CONTINUED

[For authorizations, include as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable heath information in accordance with this authorization.]

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 SIGNATURE: _____ DATE: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name: _____

Source of Authority: _____

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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 CAREFULLY.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic and paper copy of your medical record
  - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how we do this
  - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable cost-based fee.
- Ask us to correct your medical record
  - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this
  - We may say "no" to your request, but we'll tell you in writing within 60 days
- Request confidential communications
  - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
    - We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share
  - You can ask us not to use or share certain health information for treatment, payment, or our operations
    - We are not required to agree to request, and we may say "no" if it would affect your care.
  - If you pay for a service or health care item, out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
    - We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information

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- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- Get a copy of this privacy notice
  - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.
- Choose someone to act for you
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated.
  - You can complain if you feel we have violated your rights by contacting us using the information at the top of Page 1.
  - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to
    200 Independence Avenue, SW., Washington, D.C. 20201

    Calling 1-877-696-6775

    Or Visiting: www.hhs.gov/ocr/privacy/hippa/complaints/.
  - We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, we will follow your instructions.

- In these cases, you have both the right and choice to tell us to:
    - Share, information with your family, close friends or others involved in your care.
    - Share information in a disaster relief situation
    - Include your information in a hospital directory
    - Contact you for fundraising efforts
    - If you are not able to tell us your preference, for example if you're unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat or safety.
- In these cases, we never share your information unless you give us written permission:
    - Marketing purposes
    - Sale of your information
    - Most sharing of psychotherapy notes
- In the case of fundraising:
    - We may contact you for fundraising efforts, but you can tell us to not contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share health information ways:

- Treat you
    - We can use your health information and share it with other professionals who are treating you
        - Example: A doctor treating you for an injury asks another doctor about your overall health condition
- Run our Organization
    - We can use and share your health information to run our practice, improve your care, and contact you when necessary
        - Example: We use health information about you to manage your treatment and services
- Bill for your services

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- We can use and share your health information to bill and get payment from health plans or other entities
  - Example: We give information about you and your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as health and research. We have to meet any conditions in the law before we share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hippa/understanding/consumers/index.html

- Help with public health safety issues
  - We can share health information about you for certain situations such as:
    - Preventing diseases
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reduction a serious threat to anyone's health or safety
- Do research
  - We can use or share your information for health research.
- Comply with the law
  - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donor requests
  - We can share health information about your organ procurement organizations
- Work with a medical examiner or funeral director
  - We can share health information with a coroner, medical examiner, or funeral director, when an individual dies.
- Address workers' compensation, law enforcement, and other government requests
  - We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions

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- We can share health and information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health formation.
- We will let you know promptly if a breach occurs if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other an as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hippa/understanding/consumers/notice.html

Changes to the Terms of this Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received or was offered a copy of Grand Corner Dental's Notice of Privacy Practices

_____

Patient Name (Please Print)

_____

Patient, Parent, or Guardian Signature

_____

Date