PATIENT REGISTRATION (confidential information for our records)

HOW DID YOU HEAR ABOUT US: ◯ Friend ◯ Relative Name:_____

◯ Facebook ◯ Website ◯ Google ◯ Yelp ◯ Other , Please Specify_____

PATIENT INFORMATION

First Name:_____Last Name:_____MI:_____

Address:_____City/State/Zip:_____

Home Phone ( )_____Work Phone ( )_____Cell Phone ( )_____

Birth Date:_____ SS#:_____ Driver's License:_____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Employer:_____E-Mail:_____

Employment Status: ◯ full time ◯ part time ◯ retired If college student: School Attending_____

Emergency Contact:_____ Phone Number:_____

I would like to receive correspondence via: (mark all that apply) ☐ e-mail ☐ text ☐ cell phone ☐ home phone ☐ work phone

RESPONSIBLE PARTY (if someone other than the patient)

First Name:_____Last Name:_____MI:_____

Address:_____City/State/Zip:_____

Home Phone ( )_____Work Phone ( )_____Cell Phone ( )_____

Birth Date:_____ SS#:_____ Driver's License:_____

Relationship to Patient:_____

Primary Insurance Information

Name of Insured_____ Relationship to Insured: ◯ self ◯ spouse ◯ child ◯ other

Insured SSN/ID_____ Insured Date of Birth:_____

Insurance Company:_____ Employer:_____

Address:_____ Group #:_____

City, State, Zip:_____ Phone #:_____

Secondary Insurance Information

Name of Insured_____ Relationship to Insured: ◯ self ◯ spouse ◯ child ◯ other

Insured SSN/ID_____ Insured Date of Birth:_____

Insurance Company:_____ Employer:_____

Address:_____ Group #:_____

City, State, Zip:_____ Phone #:_____

ASSIGNMENT & RELEASE: I hereby authorize and request my insurance company to pay directly to Grove Dental Group the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire dental expense, I will be responsible for payment of the difference: and the nature of the liability be such that it is not covered by the policy, I will be responsible to Grove Dental Group for payment of the entire bill.

Patient/Guardian Signature:_____ Date:_____

Patient Printed Name:_____

FINANCIAL POLICY

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Welcome and thank you for choosing Grove Dental Group for your dental care! We are committed to providing you with the highest quality dental care possible in a cost-effective manner. Please understand that payment of all services is considered part of your treatment. We are happy to discuss with you any questions you may have concerning your financial arrangements.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and American Express. Several payment options are available.

1. 5% discount on services over $1000 with payment in full by cash or check *($25 fee will be applied for all returned checks)*
2. Services involving more than one visit – 50% due at start of treatment. Payments can be spread over the length of treatment but must be paid in full prior to completion of treatment. *(with manager approval – some exclusions apply)*
3. Convenient Monthly Payment Plans with Wells Fargo Health Advantage or Care Credit
    - No interest for 12 months (application and approval necessary)
    - No annual fees or pre-payment penalties
    - Extended plans available with low interest rates (ask for details)
4. Grove Dental Loyalty Plan – please ask for details!

For patients with dental insurance, we are happy to work with your carrier to maximize your insurance benefits. We will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subjected to limitations, exclusions, waiting periods, frequency, age restrictions deductibles and maximums which are your responsibility and due at the time of service. Your insurance benefits are a contract between you and your insurance company, and therefore all disputes must be handled between you and your insurance company. All charges you incur are your responsibility, regardless of your insurance coverage. **As your dental care provider, our relationship is with you, our patient, not with your insurance company. All diagnosed treatment is based on your dental health – not your insurance coverage.**

Minors accompanied by parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment of services. Unaccompanied Minors: The parent or legal guardian is responsible for full payment of services. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to the appointment or non-emergency treatment may be denied.

Missed appointments and cancellations: Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least 24 hours' notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. We reserve the right to bill for missed or cancelled appointments that are not provided with at least a 24-hour notice. A fee of $40 will be applied for such instances.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of this practice.

_____ _____

Patient's Name (Please Print) DATE

_____

Patient's Signature

Medical & Dental History

Patient Name (print): _____ **Date of birth:** _____

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions to the best of your knowledge. Understand that providing incorrect information can be dangerous to your (or patient's) health. It is your responsibility to inform the dental office of any changes in your medical status.

	Yes	No		Yes	No		Yes	No
Abnormal bleeding			Drug abuse			Osteoporosis/osteopenia		
Alcohol abuse			Emphysema			Psychiatric care		
Allergies			Epilepsy, convulsions, seizures			Radiation/chemotherapy		
Alzheimer's/dementia			Fainting spells/dizziness			Recent weight loss		
Anaphylaxis			Fever blisters/ulcers/cold sores			Renal dialysis		
Anemia/hemophilia			Frequent headaches			Rheumatic fever		
Angina			Glaucoma			STD		
Arthritis/gout			HIV+/AIDS			Shingles		
Artificial prosthesis (joints)			Heart attack/failure/disease			Sinus problems		
Asthma			Heart murmur			Sickle cell disease		
Blood transfusion			Hepatitis type __			Sinus discomfort		
Breathing/sleeping problems			High or low blood pressure			Sleep apnea		
COPD			Irregular heartbeat			Stomach/intestinal disease		
Cancer			High cholesterol			Stroke		
Chest pains			Kidney disease or problems			Swelling of limbs		
Congenital heart problems			Leukemia			Thyroid /parathyroid disease		
Colitis			Liver disease			Tonsillitis		
Diabetes			Lung disease			Tuberculosis		
Digestive disorders (reflux)			Neurologic problems (ADD/ADHD)			Tumors or growths		

Are you currently taking any prescription or over the counter medications? **If yes, list below:**

_____

Are you required to pre-medicate for dental appointments? **If yes for what condition:** _____

Medication & dosage prescribed: _____

Do you have any allergies? ◯ Yes ◯ No

Are you allergic to any medications? ◯ Yes ◯ No **If yes, please list:** _____

Do you use tobacco? ◯ Yes ◯ No

Are you pregnant or nursing? ◯ Yes ◯ No

Alcohol consumption? ◯ None ◯ Light ◯ Moderate ◯ Heavy

Recreational drug use? ◯ Yes ◯ No

Are you fearful of dental treatment? ◯ Yes ◯ No **If yes, on a scale of 1 to 10 how fearful** (1 least, 10 most) _____

Is there anyone with a history of periodontal disease in your family? ◯ Yes ◯ No

Signature of patient, parent or guardian: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

GROVE Dental Group
grow with us!

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have been offered a copy of the Statement of Privacy Practices for the office of Grove Dental Group. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

Grove Dental Group reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

☐ **My Spouse**
Spouse's name and phone number:

_____

☐ **Family Members**
Name, Relationship, Phone number:

_____

_____

_____

☐ **Caregivers**
Name, Relationship, Phone number:

_____

_____

☐ **Other**
Name, Relationship, Phone number:

_____

_____

I wish to be contacted in the following manner. Please check all that apply:

☐ **Home Telephone**
- ☐ You have my permission to leave a message with detailed information
- ☐ Leave a message with a call-back number only

☐ **Work Telephone**
- ☐ You have my permission to leave a message with detailed information
- ☐ Leave a message with a call-back number only

☐ **Cell Phone**
- ☐ You have my permission to leave a message with detailed information
- ☐ Leave a message with a call-back number only

☐ **Electronic Communication**
- ☐ You have my permission to send detailed information via email
- ☐ You have my permission to send detailed information via text

I fully understand and accept the terms of this consent.

Signature of Patient or Guardian: _____ Date: _____

Printed Name of Patient: _____ Date: _____

--- Office Use Only ---

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ **Patient Refused to Sign**

☐ **Communication Barriers prohibited obtaining the acknowledgement**

☐ **Other** _____