NEW PATIENT INFORMATION

NAME: _____ ___ Male ___ Female

DOB: _____ Status: ___ Single ___ Married ___ Divorced ___ Widowed

Address: _____, _____, _____, _____
Street Address City State Zip code

Home#- _____ Cell# - _____ Work# - _____

SS#: _____ (Required if over 18) Employer: _____

EMAIL: _____

Is the patient a college student? ___ N ___ Y where: _____

Have you had surgery in the past year? ___ No ___ Yes: _____

Family Doctor and Phone Number: _____

ALLERGIES: ___ I am NOT allergic to anything

__ Milk __ Penicillin __ Aspirin __ Amoxicillin __ Sulfa __ Ibuprofen
__ Latex __ Codeine __ Peanuts __ Other: _____

MEDICATIONS: ___ I do NOT take any medications

___ I take the following medications: (please list and indicate reason in condition section below)

_____ _____ _____ _____
_____ _____ _____ _____

CONDITIONS: (Past & Present) ___ I have not been treated for any medical conditions

___ ADD/ ADHD
___ AIDS/HIV
___ Alcohol/Drug dependency
___ Allergies (seasonal)
___ Alzheimers/Dementia
___ Anemia
___ Anxiety
___ Asthma
___ Blood Transfusion
___ Bruise easily
___ Blood Pressure
___ Cancer
___ Chemotherapy
___ Cholestrol
___ Depression
___ Diabetes
___ Emphysema
___ Heart Murmur
___ Hepatitis
___ Heart Valve Replacement
___ Herpes
___ HPV
___ Immune disorders
___ Joint Replacement
___ Kidney Diesease
___ Mental Illness
___ Osteoporosis
___ Pacemaker
___ Prolonged bleeding
___ Radiation (head/neck)
___ Respiratory problems
___ Rheumatic fever
___ Seizures
___ Stroke
___ Thyroid
___ Tuberculosis
___ Ulcers
___ Other _____

* Do you use tobacco products? ___ No ___ Yes - Frequency & length of use: _____
* Are you or have you taken bisphosphonates for osteoporosis or bone cancer? ___ No ___ Yes
* If you are female: Are you taking birth control pills? No Yes - name: _____
Are you or could you be pregnant? No Yes - due date: _____ # Weeks _____

PERSON TO BILL: ___ Patient (continue to the Dental Insurance section)

___ Parent (please complete parent information below)

NAME: _____ DOB: _____ Employer: _____

SS# : _____ (required) Cell #: _____ Email: _____

Address if different than patient's: _____

DENTAL INSURANCE: ___ NO ___ YES

** Please present copy of card and complete the section below if someone other than patient

Card holder Name: _____ Relationship to patient: ___ Spouse ___ Parent

Employer: _____ DOB: _____ SS#: _____ (Required)

Whom may we thank for referring you to our office?

___ Internet ___ Drove by ___ Advertisement ___Referred by: _____

EMERGENCY CONTACT: Name: _____

Phone: _____ Relationship to patient: _____

Previous Dentist: _____ Phone#: _____ Last seen: ____

How was your experience there? _____

Are you interested in: Cleaning/Exam / Whitening / Invisalign / Crown/Bridgework / Dentures

OFFICE AND FINANCIAL POLICY

- A 48-hour notice is required to cancel an appointment. This allows us time to fill the appointment with another patient. Cancellations will NOT be accepted via text or email. Those who cancel or fail repeatedly will be released from the practice.

- Payment is expected at the time of service. (in full for those without insurance / estimated portion for those with insurance)
  We accept cash, check, Visa, MasterCard and Discover cards.
  - For balances over $300.00 we also accept Care Credit.
  - Payment plans are offered for balances over $1000.00. (please ask for options when scheduling appointments)

- Insurance is filed as a courtesy. It is YOUR responsibility to provide the correct information and to know your policy.
- We reserve the right to turn an account over to collections at our discretion.
- Family members will be put on the same account. If there is information you do not wish to share with each other, please request separate accounts.

___ I am between the age of 18-26 listed on my parents insurance policy and give permission to Granger Dental Group to communicate with them regarding my account for insurance, billing, and/or scheduling purposes. However, I do understand that because I am of legal age, I am ultimately responsible for payment of my services.

** I have read the office and financial policy and certify that the information I have provided is correct. I authorize payment for professional services performed to: GRANGER DENTAL GROUP. I also authorize the release of any personal, medical or dental information necessary to process my insurance claim and that this document serve as my signature on file for any future dental claims.

Signature: _____ Date: _____

HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up amount the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed below to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Relationship to patient (if a minor): _____

Signature: _____ Date: _____

The following people have my permission to obtain information that is protected by the HIPAA Privacy Notice:

____ Spouse _____ ____ Child _____

____ Parents _____ ____ Other _____