Joseph Hickey D.D.S. Kevin Campbell D.D.S.
GrangerDentalGroup.com (574) 277-4235

Today's Date:

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME#: _____ WORK#: _____ CELL#: _____

SEX: M F MARITAL STATUS: S M D W SS#: _____

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

Preferred method of contact: ☐ TEXT ☐ EMAIL ☐ PHONE

Nearest Relative not living with you: _____ Phone# _____

Address: _____ Relationship: _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME: _____ RELATIONSHIP TO YOU: _____

ADDRESS: _____ HOME#: _____

DATE OF BIRTH: ____/____/____ SS#: ____-____-____ CELL#: _____

EMPLOYER: _____ OCCUPATION: _____ WORK#: _____

MEDICAL HISTORY:

FAMILY DOCTOR: _____ PHONE: _____

SPECIALISTS: _____

1.) ARE YOU ALLERGIC TO: LATEX? Y OR N PENICILLIN? Y OR N MILK? Y OR N
OTHER DRUG ALLERGIES: _____
OTHER KNOWN ALLERGIES: _____

2.) ARE YOU CURRENTLY UNDERGOING ANY MEDICAL TREATMENT? Y OR N *IF YES- PLEASE EXPLAIN*:
_____
_____

3.) PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND REASON WHY: (*Please provide copy if necessary)*
_____

4.) DO YOU SMOKE OR USE CHEWING TOBACCO? Y OR N *FREQUENCY AND LENGTH OF USE:* _____

5.) IF FEMALE, ARE YOU OR COULD YOU BE PREGNANT? Y OR N .... *DUE DATE*: _____
ARE YOU TAKING BIRTH CONTROL PILLS? Y OR N

6.) ARE YOU OR HAVE YOU TAKEN BISPHOSPHONATES FOR OSTEOPOROSIS OR BONE CANCER? Y OR N
IF YES PLEASE LIST _____

** CHECK ANY CHRONIC CONDITIONS THAT NOW OR HAVE EVER APPLIED TO YOU:

___ Diabetes	___ Anxiety	___ Depression	___ Thyroid
___ AIDS/HIV	___ Epilepsy	___ Kidney Disease	___ High/Low blood pressure
___ Allergies (Seasonal)	___ Prolonged bleeding	___ Alcohol/Drug dependency	___ Radiation (Head/Neck)
___ Artificial Heart Valve	___ Bruise Easily	___ Mental Illness	___ Blood transfusion
___ Anemia	___ Hepatitis	___ Ulcers	___ Chemotherapy
___ Arthritis	___ Herpes Virus	___ Osteoporosis	___ Heart murmur
___ Asthma	___ Pacemaker	___ Stroke	___ HPV (Human Papilloma Virus)
___ Cancer	___ Heart Conditions	___ Tuberculosis	___ Mitral valve prolapse
___ Emphysema	___ Respiratory problems	___ Venereal Disease	___ Rheumatic fever
___ OTHER: _____		___ Alzheimer's / Dementia	___ Joint Replacement

Please Present Insurance Card

Primary Carrier

Subscriber Name: _____ DOB:_____

SSN:_____ Relationship to Patient:_____

Employer: _____ Insurance ID#:_____ Group#:_____

Insurance Company: _____ Phone:_____

Insurance Company Address:_____

**Please present Secondary Insurance card if applicable*

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How did you find out about our office? _____

Previous Dentist:_____ Last seen: _____

What is the most important thing about your dental visit today?_____

Here at Granger Dental Group, we offer a variety of services to enhance your comfort, and keep your smile beautiful. Please circle any services below you would like our staff to discuss with you during your visit:

Whitening/Bleaching Invisalign or Traditional Braces Veneers Implants Sealants

Partials/Dentures Single-Visit Crowns Nighttime/Sports/Sleep Apnea Appliances

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I. PAYMENT IS EXPECTED AT THE TIME OF SERVICE. We accept cash, check, Visa, MasterCard, & Discover.

*** Patients without insurance are required to pay their service in full.**

*** Patients with insurance are required to pay their estimated portion.**

(Insurance is filed as a courtesy. The contract is between you and your insurance company.)

II. PAYMENT PLANS: If you are unable to pay your portion in full, a payment plan must be arranged prior to services.

III. WE RESERVE THE RIGHT TO TURN AN ACCOUNT OVER TO COLLECTIONS AT OUR DISCRETION.

IV. A 24-hour notice is required to cancel an appointment.

Patients or families that cancel often or fail their appointments will either be required to prepay for their services (non-refundable) or be dismissed from the practice.

V. CONSENT FOR SERVICES:

I authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs and share those diagnostic tools with appropriate services to complete treatment and financial transactions. E.g.: information may be shared with, but not limited to, dental labs, referring doctors and insurance. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risk.

VI. 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 serves as my signature on file if necessary for processing additional claims.

VII. I certify to the best of my knowledge the information that I have given is correct. If I have any change In my health, or if my medicines change, I will inform my dentist at the next appointment without fail.

SIGNATURE: _____ DATE: _____