



GREAT GRINS DENTAL

General Information

Name: _____ I prefer to be called: _____ Male Female
Last First Mi

Birth Date: _____ Social Security #: _____ Marital Status: Single Married

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ How did you hear about our office: _____

Employer: _____ Occupation: _____

Whom may we contact in case of an emergency?: _____ Phone: _____

Do you give your permission to share your information with anyone? : Yes No

If so, that person is: _____

Dental Benefits

Insurance Company: _____ Phone: _____

Plan ID#: _____ Group #: _____ Policy Holder's name: _____

Relationship to the policy holder: _____ Policy Holder's birth date: _____

Policy Holder's Social Security #: _____ Policy Holder's Employer: _____

I authorize Great Grins Dental to release any information acquired in the course of my examination or treatment to my insurance company or other care providers that I have been referred to or from whom I choose to receive care. I authorize that payment be made directly to Great Grins Dental for services rendered. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand and agree that regardless of my insurance status, I'm ultimately responsible for the balance of my account. I have read all the information on this sheet verified the above answers. I certify this information is true and correct to the vest of my knowledge. I will notify you of any changes in my status or the above information. Payment is due at the time if service unless other arrangements are agreed upon. The patient is ultimately responsible for any balance at Great Grins Dental and agrees to pay for the services performed regardless of insurance acceptance, denial or reimbursement.

Signature of Patient / Legal Guardian

Date

Medical Information

Are you currently under the care of a physician?	Yes No	Are you taking or have you recently taken any prescription or over the counter medications?	Yes No
Physician's Name/Phone		If yes, please list all, including vitamins, natural or herbal preparations, and/or diet supplements. _____ _____ _____	
Physician's Address/City/State/Zip:			
Have you had any hospitalizations or major surgeries in the last 5 years?		Women Only. Are you:	
If yes, please describe: _____ _____ _____	Yes No	Taking contraceptives?.....	Yes No
		Pregnant?.....	Yes No
		If yes, how many weeks? _____	
		Nursing?.....	Yes No

Do you have or have you had any of the following conditions? Please check all that apply.

Conditions Requiring Antibiotic

Prophylaxis

- Organ transplant
- Artificial (prosthetic) heart valve
- Previous infective endocarditis
- Damaged valves
- Congenital heart disease (CHD)

Cardiovascular Diseases

- High Blood Pressure
- Hardening of arteries
- Angina
- Congestive heart failure
- Heart attack
- Heart Bypass/Stent Surgery
- Pacemaker
- Valvular prolapse
- Any other heart or circulatory problems
- Swollen ankles
- Lower leg cramps

Blood or Lymphatic Diseases

- Anemia
- Sickle Cell Disease/Trait
- Bleeding disorder
- HIV/AIDS
- Leukemia/Lymphoma
- Any other blood disorder
- Take blood thinners e.g., (Coumadin)
- Chronic fatigue
- Easy or frequent bruising

Respiratory Diseases

- Tuberculosis
- Asthma
- Bronchitis, COPD, Emphysema
- Sleep apnea
- Persistent cough
- Coughing up blood
- Shortness of breath
- Wheezing
- Other lung condition

Liver or Gastrointestinal Diseases

- Hepatitis
- Liver cirrhosis
- Jaundice
- Gall bladder stones/disease
- GERD/Reflux/Ulcers/Heartburn
- Constipation/Diarrhea
- Blood in stool/Dark stools
- Frequent vomiting

Neurological or Mental Conditions

- Stroke/TIA/Ministroke
- Epilepsy/Seizure's
- Dementia/Alzheimer's
- Generalized Anxiety
- Depression
- Treatment for emotional condition
- Any other brain/nerve condition
- Other (i.e. Schizophrenia)

Endocrine Diseases

- Diabetes
- Thyroid disorder
- Other endocrine disease

Miscellaneous Diseases

- Arthritis
- Kidney disease
- Organ transplant
- Cancer
- Radiation therapy
- Chemotherapy
- Artificial joint/joint replacement
- Sexually transmitted disease (STD)
- Skin condition
- Night sweats
- Fever
- Unexpected weight gain/loss

HEENT Conditions

- Hear ringing or other noises
- Ear pain, discharge
- Dizziness
- Vision changes
- Blurry vision, double vision
- Glaucoma
- Runny nose, nose bleeds
- Difficulty swallowing
- Headache
- Numbness/Tingling area on face
- Any other condition not mentioned?**

Do you currently or have you used tobacco products? Yes No

Are you allergic to any of the following? (Circle all that apply)

- | | | | | |
|--------------|--------------------|---------|-------------|--------|
| Aspirin | Dental Anesthetics | Latex | Penicillin | Iodine |
| Erythromycin | Sulfa Drugs | Codeine | Other _____ | |

Dental Information

Please rate your current dental health: Good Fair Poor

Previous Dentist: _____ City/State: _____ Last Visit: _____

Are you happy with your smile? Yes No

If no, please tell us why: _____

Do you experience any of the following:

- Frequent Headaches Migraine Headaches Neck Pain
 Jaw Pain Trouble Sleeping (Insomnia)

	Yes	No
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a mouth-breather?	<input type="checkbox"/>	<input type="checkbox"/>
Are you an athlete?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in whitening options?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in Invisalign treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontics?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had trauma to your head and/or mouth?	<input type="checkbox"/>	<input type="checkbox"/>

Do you experience any of the following:

- A bad odor or taste in your mouth Bleeding when brushing or flossing
 Sensitivity to hot, cold, or sweets Food trapping between your teeth

Please tell us about any of your dental concerns or information that you feel is important for us to know: _____

Please tell us what you are looking for in a dental office:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Great Grins Dental will rely on this information for treating me. I will inform Great Grins if there are any change(s) in my health and/or medications.

Signature of Patient/Legal Guardian

Date



GREAT GRINS DENTAL

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance & Accountability Act of 1966 (HIPAA). I understand that this information can and will be used to:

- Provide & coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my services.
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed that my dental provider's *Notice of Privacy Practices* contain a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice and Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is disclosed to carry out treatment, payment, or health care operations. I 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.

Insurance and Collections

Payment is due at the time of service unless other arrangements are agreed upon. In most cases, we are able to file insurance as a courtesy to our patients. At each appointment, the patient is expected to pay the full fee for service, and will receive direct reimbursement from the insurance company. Certain necessary procedures may be excluded from coverage or considered inclusive to another procedure by your insurance company, and certain frequency limitations may apply. **The patient is ultimately responsible for any balance at Great Grins Dental and agrees to pay for the services performed regardless of insurance acceptance, denial, or reimbursement.** Please contact your insurance carrier for your benefit information as all insurance companies and plans are different.

Cancellations and No-shows

If you are unable to keep an appointment with Great Grins Dental, kindly give our office at least 24 hours notice to avoid a charge of \$50.00 for hygiene appointments and \$150.00 per 1 hour of appointed time with Dr. Fossum. We will make every attempt to contact you to confirm your appointment. Currently, we confirm appointments via email, text message, and phone calls in hopes that these added efforts will make your appointment confirmations easier. We ask that you please be responsible for keeping your appointment as a courtesy to our office as well as other patients. Please let us know if you have any changes in your contact information.

Signature of Patient/Parent if Minor

Date