GRAHAM DENTAL CARE

PATIENT INFORMATION

Name: (Last, First, MI)_____ Nickname:_____ Today's Date:_____

Address: _____
Street Apt/Ste City State Zip Code

Cell Phone #:_____ Other #:_____ Date of Birth:_____ Gender: M / F Marital Status: S / M / D / W / Child

If patient is a minor, Guardian Name, Relationship: _____ State DL/ID#:_____ SS#:_____

Email address:_____ Gmail: _____ Primary Language: _____

Insurance Policy Holder's Name:_____ SS#:_____ Date of Birth: _____

_____
Insurance Co: Group# Employer Name/Phone#

_____
Physician's Name / Phone #: Pharmacy Name / Phone #:

MEDICAL HISTORY

Do you have or have you ever had:

Y / N Anemia or other Blood Disorder
Y / N Arthritis
Y / N Asthma
Y / N ADD / ADHD
Y / N Autism
Y / N Breathing/Sleep Issue (sinus/snore)
Y / N Cancer
If yes, type: _____
Y / N Chemotherapy
Y / N Cold Sores / Viral Infections
Y / N Diabetes (HbA1c ____)
Y / N Digestive Disorders (Gastric Reflux)
Y / N Emphysema / Sarcoidosis
Y / N Epilepsy / Seizures

Y / N Excessive Bleeding (INR > 3.5)
Y / N Glaucoma
Y / N Hay Fever / Hives / Skin Rash
Y / N Head or Neck Injuries
Y / N Hepatitis (Type____)
Y / N High Cholesterol (taking statins)
Y / N HIV / AIDS
Y / N Hormone Deficiency
Y / N Kidney Disease
Y / N Liver Disease
Y / N Neurological Disorders
Y / N Organ Transplant
Y / N Osteoporosis / Osteopenia
Y / N Portal Catheter

Y / N Radiation Treatment
Y / N Rheumatic or Scarlet Fever
Y / N STI / STD
Y / N Stroke (taking blood thinners)
Y / N Thyroid/ Parathyroid Disease
Y / N Tuberculosis
Y / N Tumor / Abnormal Growth

Y / N Alcohol use
Y / N Nicotine, tobacco use
Y / N Street drug use
Y / N Female: Pregnant?
Y / N Female: taking birth control?
Y / N Male: prostate disorder?

Y / N Angina or Chest Pain
Y / N Artificial Prosthesis (joint/heart valve)
Y / N Heart Attack
Y / N Heart Disease
Y / N Heart Murmur
Y / N High / Low Blood Pressure
Y / N Infective Endocarditis
Y / N Mitral Valve Disease
Y / N Pacemaker/Implantable Defibrillator
Y / N Repaired Heart Defect (PFO)
Y / N Stents
Y / N Transplant

Other medical conditions your doctor should be aware of:_____

Allergies you are aware of:_____

Allergic reaction to medications: Latex / Local Anesthetics / Sedatives / Penicillin / Codeine / Aspirin / Sulfa / Metals / Other:_____

Medications list (include purpose of each):_____

_____

_____

_____

_____

Y / N Are you taking or have you taken bisphosphonates (bone-density medication)? Please specify: _____

Y / N Have you ever been told you need to take premed antibiotics before procedures? Please specify: _____

Y / N In the last 6 months, have you had any heart problems or cardiac stents placed? Please specify: _____

Y / N In the last 2 years, you been admitted to the hospital or needed emergency care? Please specify:_____

Y / N Have you ever experienced complications following dental treatment? Please specify:_____

ACKNOWLEDGEMENT AND CONSENT

1. To the best of my knowledge, all of the preceding answers and information are true and correct. I understand that providing incorrect or incomplete information can be dangerous to the health of the patient. If there are any changes in health, I will inform the dental clinic staff and doctors at the earliest opportunity.
2. The undersigned hereby authorizes the doctor or his/her designee to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I authorize the doctor and/ or hygienist to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.
3. I authorize and consent that the doctor and or/ hygienist choose and employ such assistance as deemed fit to provide recommended treatment.
4. I understand that all responsibility for payment for services provided in this office for myself or my dependents is mine, payable and due at the time services are rendered unless other arrangements have been made.
5. I understand that it is my responsibility to advise the appropriate office staff of any changes in the information contained on this form.
6. I certify that I have read and understand all of the information above and that, to the best of my knowledge, all of the information provided by me is accurate and correct.

Patient Name (print): _____ Date: _____

Signature of Patient, Parent or Guardian: _____ Relationship to Patient: _____

Were you referred to Graham Dental Care? If so, who can we thank? _____

GRAHAM
DENTAL CARE

Financial Policy

Our goal is to provide the finest dental care possible in a relaxed, comfortable, patient friendly environment. In an effort to keep fees down, we have eliminated many of the administrative costs with dental practice. Those costs are: billing, collections, postage, etc. The costs of those items are passed on to you, the patient, and the consumer. By eliminating those costs, we also pass those savings on to you.

Therefore, payment for services rendered is due in full on the day of service unless arrangements are made in advance. For larger appointment times and procedures with higher fees, half of the treatment cost is due at the time the appointment is made.

Insurance Claims/Processing

The patient/ guarantor are solely responsible for all charges incurred. We will gladly file and process your insurance for you, as a service, at no charge. If needed, we will re-file the claim as many times as necessary to obtain payment. Your co-pay is due at date of service. We do not guarantee payment from you carrier. This arrangement is between you and your carrier…. Not our office and your carrier.

If you would like us to wait for payment from your insurance, we will do so provided you leave a major credit card (MC, Visa, AM Express, and Discover) on file with our office. This information will be safeguarded and kept confidential. There are various reasons for non-payment beyond our control: therefore, at 45 days from the date of service, your credit card will be charged for the outstanding balance and you will be notified.

Card Type: Master Card, Visa, American Express, Discover.

Card#_____ Exp Date:_____ Vin#_____

Signature_____

Appointments

We would like to convey to you the importance of your scheduled appointment time. Our appointment times are specifically reserved for each patient. A confirmation message will be sent to you a week from the scheduled appointment date, and a reminder will also be provided 3 days prior to your scheduled appointment. We request the courtesy of 2 business days advance notice should you need to cancel or change your appointment.This courtesy allows us to give your appointment time to patients who may be waiting.

*Patients who fail to provide 24 hour advance notice may be subject to a $50 fee.

*A $75 no call / no show fee will be enforced for patients who fail to arrive for their appointed time.

I have read and understand the above terms.

Signature _____

GRAHAM
DENTAL CARE

PATIENT PHOTO RELEASE FORM

I, _____, hereby authorize Graham Dental Care to take photographs, slides and videos of my teeth, jaw and face. I understand the photographs, slides and videos will be used as a record of my care, and may be used for communication with other health professionals, educational publications (dental journals) and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook, Instagram, or any other social media platform, etc.).

I further understand that if the photographs, slides and videos are used in any publication or as part of a demonstration, my identifying information (first name only) may be used unless stated otherwise below. I further understand that if the photographs and/or videos are used, my last name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Please initial one of the following options:

_____ I agree to have my photographs used in any of the above situations

_____ I only agree to have my teeth shown without any identifying features included.

_____ I do not agree to have my photos, slides or videos used for any publication.

_____	_____	_____
Print Name	Signature	Date

NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____	_____	_____
Print Name	Signature	Date

FOR OFFICE USE ONLY

We attempt to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify) _____

_____

_____