Grand Avenue Dental

CONFIDENTIAL PATIENT INFORMATION:

*Patient's Name:*_____ *Preferred Name:* _____
Last *First* *Middle*

Date of Birth: ___/___/____ *Social Security Number:*_____

Please circle current marital status: *Married* *Single* *Child* *Divorced* *Widowed*

*Mailing Address:*_____
Street *City* *State* *Zip Code*

*Physical Address :(if different from above):*_____

Home Phone: _____ *Cell Phone :* _____ *Work Phone:*_____ *Please mark your preferred contact method. Thank you.*

Email Address: _____ *Employer:*_____

Have we treated any other family member? ____ Yes ____No
If so, whom: _____ Relationship to patient: _____

HOW DID YOU HEAR ABOUT OUR OFFICE_____

RESPONSIBLE PARTY INFORMATION FOR MINOR PATIENTS:

Name: _____ Relationship: _____
Last First Middle

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone _____

SSN: _____ Birth Date: _____ Employer: _____

DENTAL INSURANCE INFORMATION (if applicable):

Policy Holder's Name: _____ Employer: _____

What relationship to patient: _____

Social Security Number: _____ Date of Birth _____

Insurance Company & Address _____

Group Number: _____ ID# _____ Insurance Phone #_____

****

WHAT PHARMACY DO YOU USE: _____

Emergency Contact:_____ **Relationship:**_____ **Phone**_____

Signature: _____ **Date:** _____
Patient Signature or Parent/Legal Guardian Signature

Patient Medical History

Patient Name: _____ **Date of Birth :** _____
Medical Doctor Name: _____ **Height:** _____
Date of Last Exam: _____ **Weight:** _____
Phone Number of Doctor: _____

1. Are you under medical treatment now? Yes No

2. Have you ever been hospitalized for any surgical operation or serious illness?
If yes, please explain_____ Yes No
_____

3. Are you taking any medication(s) Including non-prescription medicine? Yes No
If yes, what medication(s) are you taking?

4. Do you use tobacco? Yes No
If yes, what type, quantity per day, and how long?_____

5. Do you use controlled substances? Yes No

6. Do you have or have you had any of the following?

High Blood Pressure	Yes No	Heart Murmur	Yes No	Stroke	Yes No
Heart Attack	Yes No	Angina	Yes No	Hay Fever/Allergies	Yes No
Fainting/Seizures	Yes No	Frequently Tired	Yes No	Rheumatic Fever	Yes No
Asthma	Yes No	Anemia	Yes No	Swollen Ankles	Yes No
Low Blood Pressure	Yes No	Emphysema	Yes No	Tuberculosis	Yes No
Epilepsy/Convulsions	Yes No	Cancer	Yes No	Radiation Therapy	Yes No
Leukemia	Yes No	Arthritis	Yes No	Glaucoma	Yes No
Diabetes	Yes No	Joint Replacement	Yes No	Recent Weight Loss	Yes No
Kidney Diseases	Yes No	Hepatitis/Jaundice	Yes No	Liver Disease	Yes No
Aids or HIV Infection	Yes No	Sexually Transmitted Disease	Yes No	Heart Trouble	Yes No
Thyroid Problem	Yes No	Stomach Trouble/Ulcers	Yes No	Respiratory Problems	Yes No
Artificial Heart Valve	Yes No	Congenital Heart Lesions	Yes No	Mitral Valve Prolapse	Yes No
Psychiatric Treatment	Yes No	Headaches/Migraines	Yes No	Damaged Heart Valve	Yes No
Excessive Thirst	Yes No	Persistent Cough	Yes No	Depression/Anxiety	Yes No
Easy Bruising/Bleeding	Yes No	Blood Transfusion	Yes No	Frequent Urination	Yes No
Heart Disease	Yes No	Chest Pains	Yes No	Blood Disorder	Yes No
Cardiac Pacemaker	Yes No	Easily Winded	Yes No		
Other:_____	Yes No				

7. Are you allergic to or have you had any reaction to the following?

Local Anesthetic (e.g. Novacain)	Yes	No
Penicillin or any other antibiotics	Yes	No
Sulfa drugs	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Iodine	Yes	No
Aspirin	Yes	No
Any Metals (e.g. nickel, mercury)	Yes	No
Latex Rubber	Yes	No
Other (please list)_____	Yes	No

8. **Women only:**

Are you pregnant or think you may be?	**Yes**	**No**
Are you nursing?	**Yes**	**No**
Are you taking oral contraceptives?	**Yes**	

Patient Dental History

What is your chief complaint?_____
Do you have problems with or experienced any of the following:

Bad breath, smell or taste	Yes No	Dry Mouth	Yes No	Grind or clench teeth	Yes No
Painful gums	Yes No	Bleeding Gums	Yes No	Difficulty chewing food	Yes No
Receding gums	Yes No	Sensitive Teeth	Yes No	Accident involving teeth or jaw	Yes No
Spaces developing	Yes No	Bite Changing	Yes No	TMJ or jaw joint problems	Yes No

To your knowledge, have you ever had gum disease or periodontal disease? Yes No
Have you ever had periodontal treatment or periodontal surgery? Yes No
If so, when and what procedures?_____
Do you want to change the appearance of your teeth? Yes No
If so, how can we help attain this?_____
Have immediate relatives lost most or all of their teeth? Yes No
Additional medical or dental history not covered_____

Authorization and Release
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered, I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Today's Date:_____ Signature:_____

Grand Avenue Dental

Financial Policy

Our office wants all our patients to be able to comfortably afford dental care. We will gladly discuss our payment options with you before beginning your treatment. We proudly offer the following financial policies so that our patients can have the opportunity to decide which payment option best suits your needs.

ALL PATIENTS MUST READ AND SIGN THIS FORM PRIOR TO RECEIVING SERVICES.

Dental Insurance - Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be asked to pay your deductible, co-payment, and estimated amount of your portion for the charges on the day of service is rendered. We are happy to file the forms necessary to assure you receive the full benefit of your coverage; however, many variables exist from carrier to carrier (i.e. deductible, annual maximums, allowable fee limitations, non-coverage procedures, and other restriction). **Because your annual insurance benefit is agreement among you, your human resource or employer, and your insurance company, it is you that are ultimately responsible for all charges. If your insurance benefit is set up to be paid directly to you, you are responsible to pay your insurance and your portions by the time of your appointment. Please note that the estimation of your insurance benefit for your treatment is not a guarantee of payment from them.** Please know that we will do everything possible to see that you receive the full benefits from your insurance company. However, if for some reason your insurance company has not paid or paid less than their **estimated** portion within 60 days from the start of your treatment, you are responsible for payment at that time.

Payment Options

1. **Cash, check, or Credit card**
2. **Credit Card** – Our office accepts VISA, MasterCard, and Discover.
3. **Care Credit** – For treatment over $300, patients can apply while in our office and approval is known within a few minutes. Care Credit offers 3, 6, 12, and 18 month **interest free** plans. On interest free plans, if they are not paid in the allotted time, the interest will be 22.98% and accrue from the first day.

Patient or Guardian Signature _____

Printed Name of Patient _____ Date _____

Grand Avenue Dental

Please know that we reserve your appointment exclusively for you. Therefore, if your appointment takes longer than 1 hour and 30 minutes, we require you to pay at least a half of your portion in order to reserve your chair. Thank you in advance for your cooperation.

Appointment Confirmation Policy

We will call to confirm your appointment 1 to 2 days before your appointment, we will leave a message if a voicemail box is set and open. Please note that we must have **your returned confirmation call** for your appointment in order to avoid cancellation and a fee of **$35**. If we do not have your confirmation call, we reserve the right to cancel your appointment and offer it to another patient wanting the time slot and needing treatment. We do not accept cancellations through email or voice messages.

Thank you in advance for your confirmation call in keeping your reservation.

No call no show policy

Grand Avenue Dental reserves the right to charge **$35 for any NO CALL NO SHOW or Same Day Cancellations** . Please know that we reserve your appointment exclusively for you. We strive to provide excellent care and serve the needs of all patients. If we reserve an appointment for you, and you fail to let us know at least 2 business days notice, we will charge you.

I HAVE READ AND UNDERSTOOD GRAND AVENUE DENTAL'S FINANCIAL POLICY, APPOINTMENT CONFIRMATION POLICY, AND NO CALL NO SHOW POLICY.

Patient or Guardian Signature _____

Printed Name of Patient _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:

I am required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in my possession. This notice is to inform you of the uses and disclosures of confidential information that may be made by Grand Avenue Dental, and of your individual rights and Grand Avenue Dental legal duties with respect to confidential information.

Ways in which I may use and disclose your protected Health Information:

I may use and disclose at my discretion your medical records for each of the following purposes only: Treatment, payment, and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services.
- **Payment** means activities such as obtaining payment for the health care services I provide for you.
- **Health care operations** include the business aspects of running a practice.

I may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose your protected health information to any person you identify that is involved in payment for your care.

I will use and disclose your protected health information when required by federal, state or local law. There are certain situations in which as a Doctor I am required by ethical standards to reveal information obtained during treatment to persons or agencies even if you do not give permission.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing as I am required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand my operation use of your information for treatment, payment and health care operations as stated above.

_____	_____	_____
Print Name	**Signature**	**Date**

Grand Avenue DENTAL

Consent for Dental Treatment

_____ _____

Patient's Name *Date*

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR.

_____ 1. TREATMENT:

I understand that I may have the following dental treatment performed: Fillings, Crowns, Bridges, Dentures, Extractions, Impacted tooth removal, Root Canals, Mini Implants, treatment of periodontal disease or other work deemed necessary.

_____ 2. DRUGS AND MEDICATIONS:

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

_____ 3. RISK OF DENTAL ANESTHESIA:

I understand that pain, bruising and occasional temporary or sometimes permanent numbness in lips, cheeks, tongue or associated facial structure can occur with "shots". About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

_____ 4. FILLINGS:

I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

_____ 5. CROWNS, BRIDGES, INLAYS AND ONLAYS:

I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing.I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I understand I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

_____ 6. DENTURES:

I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent". I also understand that, while I will no longer suffer from dental decay or infection, I could experience denture related problems such as; shrinking bone and gums, poor chewing ability, altered speech, reduced taste and constant denture movement. Most denture wearers become used to these symptoms quickly while other take time and there is a small number of patients who never do. Immediate dentures require frequent adjustments and one or more permanent relines within several months. I understand that failure to keep appointments may result in less than desire-able outcome. If a remake is required due to my delay, additional fees may be incurred.

_____ 7. EXTRACTIONS:

Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risk of removing teeth include, but are not limited to; pain, swelling, bleeding, infection, dry socket, fracture of bone or jaw, and loss of felling in my lip or other facial areas, cheek, tongue, gums and teeth. Such numbness may be temporary or permanent. Also, there is the possibility of a small root piece being left in the jaw, where the risk of removing it outweigh the benefits. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

_____ 8. PERIODONTAL DISEASE:

Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction , including strict observance of recall appointments. I understand that care by a specialist may be necessary.

_____ 9. ROOT CANAL THERAPY:

I realize root canal therapy has a very high success rate, however, there is no guarantee that root canal treatment will save a tooth, and complications can occur. During the procedure some complications or conditions might be noticed which would require a referral to a specialist or extraction. These include; extensive decay making the tooth un-restorable, perforations, a fractured tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier leading to persistant pain and infection. I understand that root canal files are extremely fragile instruments and may sometime separate within the root, which may or may not affect success. Teeth exhibiting extensive infection where conventional root canal therapy is not enough and might need further surgery or treatment by a specialist at additional cost to me. A small percentage of root canals fail despite the efforts. I understand that specialty care may be indicated if complications arise and any costs incurred are my responsibility. After root canal therapy, a crown is usually needed which, if not placed right away, might lead to fracture of the tooth and possible extraction.

_____ 10. MINI DENTAL IMPLANTS:

I understand the purpose of this dental implant procedure is to provide support to an existing denture or partial denture. In the event that the implants fail, they will be removed through a subsequent surgical procedure. I understand that one or more of the implants may fracture during insertion or during the implants life cycle. If a fracture occurs, I give consent to leave the implant in my jaw or remove it, under professional conditions and using professional judgment. I further understand that swelling, infection, bleeding and/or pain may be associated with this or any surgical procedure, and that said conditions may occur during the life of the implants. I also understand that temporary or permanent numbness may occur during the my tongue, lip(s), chin, gum or jaw as a result of this procedure.

_____ 11. CHANGES IN TREATMENT PLAN:

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I will have the opportunity to have all my questions answered by my doctor and I certify that I understand English. My signature below signifies that I will understand the treatment and anesthesia that be proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment my doctor has diagnosed.

_____ _____

Patient's or guardian signature *Date*