Granbury Dental Center

Registration and Health History

PATIENT INFORMATION Name (last) (first) (MI) Sex: M F DOB: / /

Age: SSN: - - Home #: Work #: Cell #:

Address: City: State: Zip: E-mail:

Reason for visit: Has any family member received treatment in this office?

How did you hear about us? What is the best appointment time for you? Morning Afternoon Evening

EMERGENCY CONTACT (relative not living with you) Name:

Phone #: Address: City: State: Zip:

RESPONSIBLE PARTY Name (last) (first) (MI)

Relation to patient: Residence: City: State: Zip:

Mailing Address: City: State: Zip:

How long at this address? Home #: Work #: Cell #:

Previous address (if less than 3 yrs.) City: State: Zip:

Employer: Occupation: # Years Employed:

SSN: - - DOB: / / Driver's License #: Marital Status:

Spouse Name (last) (first) (MI)

Employer: Occupation: # Years Employed:

SSN: - - DOB: / / Work Phone #:

DENTAL INSURANCE Insured's Name: Insurance Company:

Insurance Company Address:

Insured's Employer:

Insured's SSN: - - Group #: Local #:

DENTAL HISTORY It is important for us to know your dental and medical history. These facts have a direct bearing on your Dental Health and will be kept confidential.

How long since you have seen a dentist? Last complete dental examination? (date)

Name of previous dentist: City: State: Phone #:

How do you feel about your teeth? If you could change anything about your teeth, what would it be?

Please rank the following in order in which they would prevent you from having dental treatment (1-4). (1 = low, 4 = high)

Fear of pain #_____ Lack of concern #_____ Cost of treatment #_____ Missing work time #_____

Are you currently having problems? YES NO

What are those problems?

Is your present dental health poor? YES NO

Do you wear dentures (partial or full)? YES NO

Are you happy with your dentures? YES NO

Are you interested in permanent replacements? YES NO

Are you apprehensive about dental treatment? YES NO

Have you had any periodontal (gum) treatments? YES NO

Do your gums bleed, or feel tender or irritated? YES NO

Are your teeth sensitive to hot, cold, sweets, pressure? YES NO

Are you unhappy with the appearance of your teeth? YES NO

Are you aware of grinding or clenching your teeth? YES NO

Do you have headaches, earaches, or neck pain? YES NO

Have you worn braces on your teeth (orthodontics)? YES NO

Do you have discolored teeth that bother you? YES NO

Would you like your smile to look better or different? YES NO

Do you regularly use dental floss? YES NO

MEDICAL HISTORY Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Rheumatism	☐	☐
Allergies (Seasonal)	☐	☐	Drug Addiction	☐	☐	HPV (Human Papilloma Virus)	☐	☐	Scarlet Fever	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Seizures	☐	☐
Angina (Chest pain)	☐	☐	Epilepsy	☐	☐	Jaw Joint Pain	☐	☐	Sinus Problems	☐	☐
Arthritis	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Sleep Apnea	☐	☐
Artificial Heart Valve	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Stomach Problems	☐	☐
Artificial Joints	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Heart Conditions	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease	☐	☐
Blood Disease	☐	☐	Heart Lesions (Congenital)	☐	☐	Nervousness/Depression	☐	☐	Tuberculosis	☐	☐
Bruise Easily	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Ulcers	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Pre-Medicate	☐	☐	Other _____		
Cervical Cancer	☐	☐	Hepatitis A	☐	☐	Pregnant Currently	☐	☐			
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Radiation (head/neck)	☐	☐			
Cortisone Medication	☐	☐	Hepatitis C	☐	☐	Respiratory Problems	☐	☐			
Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever	☐	☐			

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO
Aspirin	☐	☐	Percodan	☐	☐	Tetracycline	☐	☐	Valium	☐	☐
Darvon	☐	☐	Latex	☐	☐	Codeine	☐	☐	Penicillin	☐	☐
Nitrous Oxide	☐	☐	Local Anesthetic	☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐

Other _____

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	☐	☐	Zometa	☐	☐
Aredia	☐	☐	Boniva	☐	☐
Fosamax	☐	☐	Herbal Supplements	☐	☐
Reclast	☐	☐			

Are you under a physician's care? What for?

_____

What medications are you currently taking?

_____

Family Physician _____ Phone Number _____

THE EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale (ESS) was developed and validated by Dr. Murray Johns of Melbourne, Australia. It is a simple, self-administered questionnaire, widely used by sleep professionals in quantifying the level of daytime sleepiness.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling "just tired"? This refers to your usual way of life at present and in the recent past. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would never doze **1** = slight chance of dozing **2** = moderate chance of dozing **3** = high chance of dozing

SITUATION	SCORE
Sitting and reading	
Watching Television	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Johns MW. A new method for measuring daytime sleepiness:
The Epworth Sleepiness Scale. Sleep 1991; 14 (6): 540-5

TOTAL: _____

TMJ QUESTIONNAIRE These questions are useful in identifying jaw joint disorders and related headaches.

PLEASE CHECK ALL THAT APPLY:

Do you have difficulty or pain opening your mouth	☐	Do you have either "clicking" or "popping" in either jaw joint	☐
Is your jaw stiff, tight, or tired	☐	Do you have headaches or facial pain	☐
Do you have difficulty or pain when chewing	☐	Do you clench or grind your teeth during the day or night	☐

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Please print name: _____

Signature: _____ Date: _____

Authorization To Release Information

I,_____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. By signing below you authorize us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose without reimbursement. Please note that payment of your bill is considered part of your treatment. Payment is due at time service is provided. Our office accepts cash, personal checks, MasterCard, American Express, Visa and Discover Card.

Our payment option and discount policy is as follows:

- Payment in full on initial date of service for 5% cash / check discount – entire treatment plan total must be paid on or before initial date of service and total must be over $1000 to receive the discount. Insurance (if any) will be paid directly to the patient and will not be a factor in the total cost. As a courtesy, our office will bill the insurance coverage but not be responsible for their payment made.
- Pay patient portion after ESTIMATED insurance coverage – we ask that you pay your deductible and the estimated amount not covered by your insurance plan by cash, check, debit or any of the credit cards listed above on the date of service. No discount or payment arrangements will be given for payment of this amount. Pay patient portion after ESTIMATED insurance coverage – we ask that you pay your deductible and the estimated amount not covered by your insurance plan by cash, check, debit or any of the credit cards listed above on the date of service. No discount or payment arrangements will be given for payment of this amount.
- ½ and ½ option – not available for new patients within 6 mos. of initial visit. Payment may be split between two consecutive months. It is mandatory for an auto draft of a debit/credit card on a prearranged date be set for this payment option. The auto draft consent will allow our office to conduct additional attempts to run the card number provided if initial payment is denied. The attempts will be unlimited until payment is achieved and balance is collected. The first payment is due on initial date of service. If the treatment includes additional visits to finish work the second payment must be run before work can be completed. This option will not allow for a discount.
- 1/3, 1/3 & 1/3 option - not available for new patients within 6 mos. of initial visit. Payment may be split between three consecutive months. It is mandatory for an auto draft of a debit/credit card on two prearranged dates be set for this method. The auto draft consent will allow our office to conduct additional attempts to run the card number provided if initial payment is denied. The attempts will be unlimited until payment is achieved and balance is collected. The first payment is due on initial date of service. If the treatment includes additional visits to finish work all payment must be run before work can be completed. This option will not allow for a discount.

Special Financing Options:
We offer Care Credit and Comprehensive Dental Finance as two outside financing sources that are available upon request. That request will require our office to check your credit score and personal information, which we are obligated to keep confidential. Our office is not party to or responsible for any terms or agreements made between you and any outside finance company.

If you have insurance:

- As a courtesy to you we will help you process all your primary dental insurance claims. Please understand that we will provide an insurance estimate for you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course do all we can to ensure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract. Our office will not be liable for any contractual obligations or network approved discounts for any insurance carrier. In addition, as our office is an out of network provider, some insurance companies will determine to reimburse the insured only. If your insurance company's processing policy determines to pay the insured only, you will be responsible for all charges in full on the date of service incurred.
- Our practice is committed to providing the best treatment for our patients and charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Insurance payments are made generally made within 30-60 days from time of filing. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. If your insurance company has not made payment within 60 days we ask that you call your insurance company to ensure payment will be made. If payment is not received or your claim is denied for any reason, you will be responsible for paying the remaining amount in full. Our office will not, however, enter into a dispute with your insurance company over any claim.

Past due accounts / Returned checks:
Your account will be subject to a minimum fee of $25.00 for any returned checks. Those checks may be turned over to Hood County "Hot Check Collection Division" for prosecution and collection. In the event it becomes necessary for our office to enlist a collection service, county service and/or legal assistance, you will be responsible for any additional collection fees and/or legal charges. You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transfer of Records:
You will need to request in writing and pay a minimum $25 fee for any copies of your records. The exact fee will be determined by the number of pages that need copied.

I have read, understand and agree to the above terms and conditions. I authorized my insurance company to pay my dental benefits directly to my dental office (if applicable). I understand that I hold full responsibility for payment of dental services provided in this office for myself or my dependents. These charges are payable at the time of service are rendered.

_____ _____

Patient or Responsible Parent of Child Date

Granbury Dental Center