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 reponsible 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? If yes, please list all, including vitamins, natural or herbal preparations, and/or diet supplements. ________________ ________________ ________________	Yes No
Physician's Name/Phone			
Physician's Address/City/State/Zip:			
Have you had any hospitalizations or major surgeries in the last 5 years? If yes, please describe: ________________ ________________ ________________	Yes No	**Women Only. Are you:** Taking contraceptives?...................................... Pregnant.. If yes, how many weeks? _______ Nursing?..	Yes No Yes No 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?	☐	☐
Do you clench or grind your teeth?	☐	☐
Are you a mouth-breather?	☐	☐
Are you an athlete?	☐	☐
Are you interested in whitening options?	☐	☐
Are you interested in Invisalign treatment?	☐	☐
Have you ever had orthodontics?	☐	☐
Have you ever had trauma to your head and/or mouth?	☐	☐

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 1996 (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 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. 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