New Patient Registration

Patient Information *(Individual being treated)*

Please Provide Copy of Driver's License

First Name: ____ Last Name: _______________________________________

Mailing Address: ____________________________________ City: ______________________State: ______ Zip: __________

Birth Date: _______________ Home Phone: ________________ Work Phone: ______________ Cell Phone: ______________

Gender: ☐ Male ☐ Female (E-mail): ____

Social Security Number:____

Person to Contact in Case of Emergency: _______________ Relation: ________________ Phone: ______________

Financially Responsible Party *(Person responsible for balances on account)*

First Name: ____ Last Name: _______________________________________

Mailing Address: ____________________________________ City: ___________________ State: ________ Zip: ____________

Birth Date: _______________ Home Phone: ________________ Work Phone: ______________ Cell Phone: ______________

Gender: ☐ Male ☐ Female (E-mail):

____

☐ *Responsible Party is also a Policy Holder for Patient* ☐ *Primary Insurance Policy Holder* ☐ *Secondary Insurance Policy Holder*

Who may we thank for referring you?____

Other Referrals ☐ Internet ☐ Doctors Referral ☐ Walk by ☐ Drive By

I am interested in (Please check all that apply)

- ☐ General Dentistry
- ☐ Cosmetic Smile Makeover
- ☐ Teeth Whitening
- ☐ Clear Aligner Therapy or Straighter Teeth
- ☐ TMJ or Teeth Grinding
- ☐ Snoring/Sleep Apnea
- ☐ Endodontics
- ☐ Implants (Single or Dentures)
- ☐ Oral Surgery (Extractions, Wisdom Teeth Removal, Sinus Lift)
- ☐ Full Mouth Makeover

Primary Benefit Information

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of **individual Policy Holder**: ________________________ Name of **Benefit Company**: _____________________

Policy Holder Employer: _________________________________ **Benefit Company** Address: _____________________

Employer Address: ____________________________________ City, State, Zip: ______________________________

City, State, Zip:____ Member ID: _________________________________

Policy Holder Birth Date: ________________________________ Group Number: ______________________________

Policy Holder SSN: _____________________________________**Benefit Company** Phone # _____________________

Secondary Benefit Information

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of **individual Policy Holder**: ________________________ Name of **Benefit Company**: _____________________

Policy Holder Employer: _________________________________ **Benefit Company** Address: _____________________

Employer Address: ____________________________________City, State, Zip: ______________________________

City, State, Zip:____ Member ID: _________________________________

Policy Holder Birth Date: ________________________________ Group Number: ________________________

Policy Holder SSN: _____________________________________**Benefit Company** Phone # _____________________

Ask About Our Membership

The Grant Family Dentistry Membership plan is designed to provide affordability and greater access to quality dental care. You will receive immediate, hassle-free, and convenient eligibility. Dental services will be provided by the Grant Family Dentistry team.

This is a membership plan to provide affordable dental care, not dental insurance, or benefit plan. The plan may be enhanced as our services progress in the advancement of quality care. Patient portion is due at the time of service.

We make it simple for your investment to provide continuous care through our automatic renewal process.

Benefits of our membership:

- No deductible
- No annual maximum
- No pre-authorization
- No wondering what your benefits will pay toward your treatment
- No waiting period

Medical History

Dental History

Do you have a specific dental problem? Describe ______________________ Yes No

Do you have dental exams on a routine basis? Last Visit ______________________ Yes No

Do you think you have active decay or gum disease? ______________________ Yes No

Do you brush or floss on a routine basis? Discuss______________________ Yes No

Do your gums ever bleed? Discuss ______________________ Yes No

Do you like your smile? Why? ______________________ Yes No

Does food catch between your teeth? Any loose teeth? ______________________ Yes No

Do you want to keep your remaining teeth? ______________________ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ______________ Yes No

Do you smoke or chew? Any sores or growths in your mouth? Discuss? ______________________ Yes No

Sleep/Airway Issues

Does the patient tend to be a mouth breather? YES NO

Does the patient snore at night? YES NO

Does the patient seem rested in the morning? YES NO

Is the patient often sleepy during the day? YES NO

Has the patient seen an ENT specialist? YES NO

Is the patient using a sleep apnea device? YES NO

Medical History

Are you under a physician's care now? ______________________ Yes No

Have you ever been hospitalized or had a major operation? Discuss ______________________ Yes No

Have you ever had a serious injury to your head or neck? Discuss ______________________ Yes No

Are you taking any medications: aspirin, vitamins, herbals, pills or drugs? What? ______________ Yes No

Are you on a special diet? Discuss ______________________ Yes No

Are you allergic to any medications or substances? Please check box below

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local anesthetics
☐ Other ______________________

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

***Do you now have or have you ever had any of the following?**

- AIDS/HIV Positive
- Alzheimer's Disease
- Anemia
- Angina/Chest Pain
- Arthritis/Gout
- Artificial Heart Valve
- Artificial Joint
- Asthma
- Bacterial Endocarditis
- Blood Disease/Bruise Easily
- Blood Transfusion
- Bloody Sputum
- Breathing Problems/Easily Winded
- Cancer
- Chemotherapy
- Cold Sores/Fever Blisters
- Congenital Heart Disorder
- Convulsions
- Coronary Stent
- Cortisone Medicine
- Diabetes
- Drug Addiction/Alcoholism
- Emphysema
- Epilepsy or Seizures
- Excessive Bleeding
- Excessive Thirst
- Fainting or Dizziness
- Frequent Cough
- Frequent Diarrhea
- Frequent Headaches
- Genital Herpes
- Glaucoma
- Hay Fever
- Heart Attack/Failure
- Heart Murmur or Defect
- Heart Diseases/Surgery
- Heart Pacemaker
- Hemophilia
- Hepatitis A
- Hepatitis B or C
- Herpes
- High Blood Pressure
- High Cholesterol
- Hives or Rash
- Hypoglycemia
- Irregular Heartbeat
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Lung Disease
- Mitral Valve Prolapse
- Osteoporosis
- Pain in Jaw Joints
- Parathyroid Disease
- Psychiatric Care
- Radiation Treatment
- Recent Weight Loss
- Renal Dialysis
- Rheumatic Fever
- Rheumatism
- Scarlet Fever
- Shingles
- Sickle Cell Disease
- Sinus Trouble
- Spina Bifida
- Stomach/Intestinal Disease
- Stroke
- Swelling of Limbs
- Thyroid Disease
- Tonsillitis
- Tuberculosis
- Tumors or Growths
- Ulcers
- Venereal Disease
- Yellow Jaundice

Have you ever had any other serious illness not checked above? Discuss ____________________ Yes No

To the best of my knowledge, all preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X____ Date: ____

Office and Financial Policies

Thank you for choosing Grant Family Dentistry to care for all your dental needs. Our goal as your dental care provider is to create a pleasant and comfortable experience both in the dental chair and at the financial desk.

You, as the holder of the benefit policy, are ultimately responsible for knowing what your plan does and does not cover and the administrative rules, such as referrals and authorizations. In order to provide comprehensive quality care to our patients, we are an **out of network provider**. As a courtesy to our patients, we will submit all your claims on your behalf. Most benefit companies pay similar regardless of in or out of network.

Any amounts not covered by your plan are your responsibility. Please take some time to read over our Office Policies below so that we can establish a mutual understanding of how our relationship works. Please read and initial each item below.

Appointments:

- For your convenience our regular office hours are as follows: Mondays, Wednesdays, and Thursday 8:00am to 4:00pm with a lunch hour between 12:00pm and 1:00pm. Tuesdays from 9:00am to 4:00pm with a lunch hour between 12:00pm and 1:00pm. These times may change around holidays.
- Please be on time for your reserved appointments. We have exclusively reserved the doctor, team, and facility for your personal dental care. If you need to reschedule an appointment, please let us know **48 hours** in advance. **If an appointment is cancelled or rescheduled within the 48 hours before the appointed time, $50 per scheduled hour will be charged to your account.**
- If you are fifteen or more minutes late for your appointment it will be considered a **"no show"** and rescheduled to another day. **You will be assessed a $50 per scheduled hour charge to your account.**
- For any appointment's scheduled for one hour or longer we require **10% NON REFUNDABLE DEPOSIT** of the total treatment scheduled for that day. We will retain the deposit if the appointment is rescheduled within 48 hours before the appointment.
- We encourage our patients to tell their family and friends about us. If you refer someone to our practice, you will receive a $25 gift card.

Initials________

Fees:

- Our office believes our fees are a fair representation of the standard of care we provide and are in-step with the industry standard. It is having a fee for service practice that allows us to deliver the first-class quality and services you receive. The treatment plan will be regularly updated with current fees if not scheduled within 90 days of treatment presentation.
- Initials________

Copay and Deductibles:

- Estimated patient out of pocket investments are due at every visit. I understand that the dental benefits available are conditional on the patient's employment status, plan eligibility, payment of premium, amount of benefits remaining, plan provisions and plan exclusions. The benefits quoted are not a guarantee of payment. Final determinations to benefits payable will be made at the time the claim is submitted for payment. **Benefits not paid by the benefit company are the responsibility of the patient.**
- Initials________

New Benefit Information

- **New benefit information must be provided prior to my appointment date.** I agree to provide this information before I am seen. **Failure to provide correct benefit information may result in the entire bill being my own responsibility.**
- Initials________

Balances:

- After my benefit plan has processed the claim**, remaining balances are due immediately upon receipt of a bill from the office**. If I disagree with the amounts due per the benefit Explanation of Benefits, **it is my responsibility to immediately contact my benefit company** for resolution of the problem. **I understand that I may not withhold payment to Grant Family Dentistry pending resolution of the benefit problem**. If the benefit company corrects the problem, I understand that my account will be credited, or I will be refunded any overpaid amounts.

  - Initials________

Benefit Requests For Additional Information:

- I understand that benefit companies request for additional information necessary to process claims must be responded to immediately. These include requests to verify other benefit coverage, full-time student status, etc. Failure to provide this information in a timely manner may result in the entire bill being my responsibility.

  - Initials________

Payments:

- Payment is due when services are rendered. An estimate of your treatment fees will be outlined in detail with you at the time of your initial visit, or at follow up treatment consultation.
- We accept Cash, Personal Checks, Visa MasterCard, Discover, and American Express.
- We also work with 3rd Party Financing companies: Care Credit and Alphaeon.
- We offer in house pre-payment plans that allow payments to be made leading to your appointment.

  - Initials________

Billing:

- Bills are sent out at the beginning of the month and as needed throughout the month. Please remit payment for or contact the office to pay by credit card any balances due immediately upon receipt of a bill. **I agree to contact the office immediately if I have questions regarding a bill I receive.**

  - Initials________

Balances Over 90 Days:

- I understand that if I allow my account balance to exist more than 90 days, I may receive a Final Notice Letter. Failure to pay my account or arrangements with the office within 10 days may result in my account being turned over to a collection agency. The collection fees incurred due to the delinquent account will become my responsibility. I understand that the collection agency will report unpaid balances to all major credit bureaus. Before I can be seen in this office again, I understand that all fees, commissions, and taxes relating to the collection agency involvement must be paid.

  - Initials________

Changes In Address:

- Changes in address or telephone numbers should be provided immediately. I will not wait until the next appointment, as bills or other correspondence will not reach me without a valid address and phone number on file. I understand that if the office cannot contact me via telephone or mail, my account will be turned over to a collection agency for further collection activity. (See Balances Over 90 Days for additional information on collection policies)

  - Initials________

Returned Checks:

- A fee of $25 will be incurred if a check is returned. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. If a second check is returned on my account, I understand that the office will no longer accept personal checks for payment.

  - Initials________

Again, we thank you for choosing Grant Family Dentistry to care for your dental needs. We appreciate your trust and look forward to serving you. If you have any questions regarding our financial policies, please don't hesitate to ask. Please sign below to acknowledge understanding of the entire policy and that you were provided with a copy for your records.

Patient Printed Name: ____

Parent/Guardian Printed name: _____________________________________

Signature of Patient/Guardian: ______________________________________ Date: _____________

Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIIPPA), there are certain rights to privacy regarding my protected health information. I understand that this information will be used to:

*Contract, plan, and direct any treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third party payers
*Conduct normal healthcare operations such as quality assessments and physical certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I understand that this office has the right to change the Notice of Privacy Practices from time to time, and that I may contract the practice at any time at the address above, to obtain a current copy of the Notices of Privacy Practices

I understand I may request, in writing, that you restrict how my private information is used and disclosed to carry out treatment, payment or healthcare operations. I also understand you are required to agree to my requested restrictions and if you do agree, then you are bound to such restrictions.

Patient Printed Name: ____

Parent/Guardian Printed name: ____

Signature of Patient/Guardian: ____ Date: ______________

Mission

Our Mission to create an impact that changes the world around us. We believe in serving our patients by providing the best care possible.

Our Core Values

Excellence: We pursue excellence in everything we do.

Positivity: We maintain a positive state of mind, regardless of circumstance.

Efficiency: We use simple and efficient systems to maintain punctuality.

Authenticity: We are authentic in our interactions, and genuinely believe in our team's values.

Growth: We thirst for personal and professional development.

Selfless: We selflessly serve our patients and each other.

Your Rights

Restrictions: You have the right to request restrictions or disclosure of usage. We are not required to accept these restrictions, but we will make a note of the request and honor that request if applicable.

Access: You have the right to access your personal health information. A request for access must be made in writing. You may speak to our office manager to schedule an appointment to view your information. You may also request a copy of your personal health information.

Amendment: You have the right to request that we amend your personal health information. Your request must be in writing and explain what should be amended and the rationale for such a request. We have the right to deny this request if we feel that it would render your information inaccurate. We will inform you of the decision to amend your information.

Disclosures: You have the right to request a list of the times and entities to whom we have disclosed your personal health information. These disclosures are only for instances other than treatment, payment, or operations. This disclosure will be given free on an annual basis if requested. We reserve the right to charge for this if requested more than once in a 12-month period.

Record Maintenance

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies, but you will be informed of any changes in advance. We will only release information about you and your treatment under specific circumstances. These include, but are not limited to the following:

Treatment: We may use your information during treatment. This includes releasing information to other dentists, physicians, other health care providers, lab technicians and our staff.

Payment: We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes benefit carriers, claims clearing houses, collection agencies, and third-party administrators such as employee medical reimbursement accounts.

Operations: We may use your personal information during operations of our office. This may include quality assurance/quality improvement reviews, credentialing, training, and certification and accreditation activities.

Miscellaneous Uses: At certain times we may be required to use your information for other purposes than as described above. Examples of these include: appointment reminders (cards, voice messages, and letters), abuse/neglect, national security, immediate family and friends (only to the extent for use in healthcare operations or payment), schools (letter excusing absence due to dental treatment), education (use of information in presentations or lectures regarding treatment or procedure), advertising, and in some cases to law enforcement and court ordered releases (coroner, worker's compensation, automobile policies, and life insurance policies).