Grand Dental

Office Use Only

ID _____ Chart ID _____

Patient Registration

First Name _____ Last Name _____ Middle Initial ____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name _____

Responsible Party (if someone other than the patient)

First Name _____ Last Name _____ Middle Initial ____

Address _____ Address 2 _____

City, State, ZIP Code _____

Home Phone _____ Work Phone _____ Ext. ____ Cell Phone _____

Date of Birth __/__/____ Social Security Number _____ Drivers License Number _____

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

Patient Information

Address _____ Address 2 _____

City, State, ZIP Code _____

Home Phone _____ Work Phone _____ Ext. ____ Cell Phone _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth __/__/____ Age ____ Social Security Number _____ Drivers License Number _____

Email _____ ☐ I would like to receive correspondence via email.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID _____ Preferred Dentist _____

Employer ID _____ Preferred Pharmacy _____

Carrier ID _____ Preferred Hygenist _____

Primary Insurance Information

Name of Insured _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security Number _____ Insured Birth Date _____

Employer _____ Insurance Company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, ZIP Code _____ City, State, ZIP Code _____

Rem. Benefits _____ Rem. Deductions _____

Secondary Insurance Information

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

Insured Social Security Number _____ Insured Birth Date _____

Employer _____ Insurance Company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, ZIP Code _____ City, State, ZIP Code _____

Rem. Benefits _____ Rem. Deductions _____

Grand Dental

Patient Name _____

Birth Date __/__/____ Date Created __/__/____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐Yes ☐No If Yes: _____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No If Yes: _____

Have you ever had a serious head or neck injury? ☐Yes ☐No If Yes: _____

Are you taking any medications, pills, or drugs? ☐Yes ☐No If Yes: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No If Yes: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ☐Yes ☐No If Yes: _____

Are you on a special diet? ☐Yes ☐No If Yes: _____

Do you use tobacco? ☐Yes ☐No If Yes: _____

Women: Are you... ☐Pregnant/trying to get pregnant? ☐Nursing? ☐Taking oral contraceptives?

Are you allergic to any of the following? ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Sulfa Drugs ☐Local Anesthetics ☐Other _____

Do you use controlled substances? ☐Yes ☐No If Yes: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐Yes ☐No	Diabetes ☐Yes ☐No	Hepatitis B or C ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No
Alzheimer's Disease ☐Yes ☐No	Drug Addiction ☐Yes ☐No	Herpes ☐Yes ☐No	Rheumatism ☐Yes ☐No
Anaphylaxis ☐Yes ☐No	Easily Winded ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Scarlet Fever ☐Yes ☐No
Anemia ☐Yes ☐No	Emphysema ☐Yes ☐No	High Cholesterol ☐Yes ☐No	Shingles ☐Yes ☐No
Angina ☐Yes ☐No	Epilepsy or Seizures ☐Yes ☐No	Hives or Rash ☐Yes ☐No	Sickle Cell Disease ☐Yes ☐No
Arthritis/Gout ☐Yes ☐No	Excessive Bleeding ☐Yes ☐No	Hypoglycemia ☐Yes ☐No	Sinus Trouble ☐Yes ☐No
Artificial Heart Valve ☐Yes ☐No	Excessive Thirst ☐Yes ☐No	Irregular Heartbeat ☐Yes ☐No	Spina Bifida ☐Yes ☐No
Artificial Joint ☐Yes ☐No	Fainting Spells/Dizziness ☐Yes ☐No	Kidney Problems ☐Yes ☐No	Stomach/Intestinal Disease ☐Yes ☐No
Asthma ☐Yes ☐No	Frequent Cough ☐Yes ☐No	Leukemia ☐Yes ☐No	Stroke ☐Yes ☐No
Blood Disease ☐Yes ☐No	Frequent Diarrhea ☐Yes ☐No	Liver Disease ☐Yes ☐No	Swelling of Limbs ☐Yes ☐No
Blood Transfusion ☐Yes ☐No	Frequent Headaches ☐Yes ☐No	Low Blood Pressure ☐Yes ☐No	Thyroid Disease ☐Yes ☐No
Breathing Problems ☐Yes ☐No	Genital Herpes ☐Yes ☐No	Lung Disease ☐Yes ☐No	Tonsilitis ☐Yes ☐No
Bruise Easily ☐Yes ☐No	Glaucoma ☐Yes ☐No	Mitral Valve Prolapse ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Cancer ☐Yes ☐No	Hay Fever ☐Yes ☐No	Osteoporosis ☐Yes ☐No	Tumors or Growths ☐Yes ☐No
Chemotherapy ☐Yes ☐No	Heart Attack/Failure ☐Yes ☐No	Pain in Jaw Joints ☐Yes ☐No	Ulcers ☐Yes ☐No
Chest Pains ☐Yes ☐No	Heart Murmur ☐Yes ☐No	Parathyroid Disease ☐Yes ☐No	Venereal Disease ☐Yes ☐No
Cold Sores/Fever Blisters ☐Yes ☐No	Heart Pacemaker ☐Yes ☐No	Psychiactric Care ☐Yes ☐No	Yellow Jaundice ☐Yes ☐No
Congenital Heart Disorder ☐Yes ☐No	Heart Trouble/Disease ☐Yes ☐No	Radiation Treatments ☐Yes ☐No	
Convulsions ☐Yes ☐No	Hemophilia ☐Yes ☐No	Recent Weight Loss ☐Yes ☐No	
Cortisone Medicine ☐Yes ☐No	Hepatitis A ☐Yes ☐No	Renal Dialysis ☐Yes ☐No	

Have you ever had any serious illness not listed? ☐Yes ☐No If Yes: _____

Comments _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian

x _____ Date __/__/____

Grand Dental

Statement of Financial & Information Policy

Thank you for choosing our office for your dental care. The following is a statement of our financial policy. We ask that you read it prior to your first visit with us.

We will gladly process your insurance claims as a courtesy to you, provided that you give us accurate information. It is your responsibility to inform us of any changes in insurance coverage. Your insurance coverage is a contract between the policyholder's employer and the insurance company! All co-pays and co-insurance are due at the time of service. If your insurance fails to pay, you will be responsible for the remaining balance on your account. If you have no insurance, you will need to pay the balance in full, unless prior arrangements have been made. For extensive treatment plans, we offer extended payment plans with prior credit approval through Care Credit.

By signing this form, you are consenting to the following:

- examination, diagnostic studies, and treatment as deemed appropriate by Grand Dental,
- release of information concerning that care for insurance purposes or further dental care when necessary,
- payment of authorized benefits to be made on your behalf to Grand Dental for any services furnished by this provider, and
- authorize any holder of dental or medical information about me to be released if needed to determine these benefits or benefits payable for related service.

In the course of providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The “Notice of Privacy Practices” that are available for your review describes these uses and disclosures in detail.

_____ _____

Signature of Patient Date

or

_____ _____

Signature of Responsible Party Date

_____

Relationship to Patient

Grand Dental Studio
Dr. Nicholas Matthews D.D.S & Dr. Chandler Robertson D.D.S
948 South Jefferson Avenue Springfield, MO
417-865-8405

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____

Patient address _____

Patient phone number _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS information about substance abuse treatment, and information about mental health services] under the following terms and conditions,

1. Detailed description of the information to be released:

2 To whom may the information be released [name(s) or class(es) of recipients]:

3 The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form

Relationship to Patient_____Print Name _____