***WELCOME TO GRANITE FALLS DENTAL CARE!***

Thank you for choosing our dental healthcare team! We will strive to provide you with the best possible dental care. To assist us in meeting all of your dental health needs, please fill out this form completely; using only blue/black ink. If you have any questions or need assistance with this form, please ask us, we will be happy to help.

**Patient Information**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT LAST NAME FIRST M.I. | | | PREFERRED NAME | TODAY’S DATE | | | MALE  FEMALE |
| BIRTHDATE MM/DD/YYYY | SOCIAL SECURITY #(not minors) | | HOME PHONE | | MARITAL STATUS  S M D OTHER | | |
| EMAIL ADDRESS | | | CELL PHONE | | DRIVER’S LICENSE NUMBER | | |
| ADDRESS APPT/SPACE | | | CITY | | | STATE | ZIP CODE |
| EMPLOYER SELF NONE RETIRED | | | BUSINESS PHONE | | | OCCUPATION | |
| EMERGENCY CONTACT | | RELATIONSHIP | | THEIR PHONE # | | | |
| WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? | | | | RELATIONSHIP | | | |

**Responsible Party (if patient is a minor)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PERSON RESPONSIBLE LAST NAME FIRST M.I. | | | | RELATIONSHIP | DRIVER’S LICENSE NUMBER | | | |
| BIRTHDATE MM/DD/YYYY | HOME/CELL PHONE | EMAIL | | | | SOCIAL SECURITY # | | |
| HOME ADDRESS SAME AS ABOVE | | | CITY | | | | STATE | ZIP CODE |
| EMPLOYER SELF NONE RETIRED | | | BUSINESS PHONE | | | OCCUPATION | | |

**Insurance Release:** To the extent permitted under applicable law, I hereby authorize release of any information relating to all

claim for benefits submitted on behalf of myself and/or my dependants. I hereby assign and authorize payment of dental

benefits otherwise payable to me, directly to the office of Granite Falls Dental Care. I agree that a photocopy of this

document and authorization may act as a n original and that my signature below shall authorize payment to the dentist for

any services rendered to me or my dependants as if I had signed each benefit assignment of future claims.

Patient/Parent/

Guardian Signature Date

***AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS***

**May leave a detailed message:** (Please check all that apply)

* Voicemail at home #: ( )
* Voicemail at work #: #: ( )
* With spouse/other family member (name):
* Cell phone or send text to #:
* Email to :

With my signature below, I acknowledge and understand that this information will be kept in my medical

Record and the above parameters will be abided by until revoked by me in writing. It is my responsibility

to notify my healthcare provider should I change one or more of the telephone numbers listed above.

**Patient (Parent/Legal Guardian) Signature: Date:**

***GRANITE FALLS DENTAL CARE***

**MEDICAL HEALTH QUESTIONNAIRE**

**Patient Name: Date of Birth:**

***Are you under medical treatment now? Yes No***

If yes, please explain:

***Have you ever been hospitalized for any surgical operation or serious illness? Yes No***

If yes, please explain:

***Are you taking any medications? Yes No***

If yes, please list all medications?

***Do you now have or have you ever had any of the following? (Please answer each question)***

**Yes / No** Heart Disease / Heart Condition **Yes / No** Chest Pain **Yes / No** Blood Pressure Problems High / Low

**Yes / No** Heart Murmur **Yes / No** Heart Valve Problem **Yes / No**  Rheumatic Fever

**Yes / No**  Pace Maker **Yes / No**  Stroke **Yes / No** Abnormal Bleeding

**Yes / No** Leukemia **Yes / No** Sinus Problems **Yes / No** Skin Rashes

**Yes / No** Asthma **Yes / No**  Intestinal Problems **Yes / No** Ulcer or Stomach Problems

**Yes / No** Kidney or Bladder Problems **Yes / No** Joint Replacement **Yes / No** Back or Neck Problems

**Yes / No** Arthritis **Yes / No** Autism or Sensory **Yes / No** Alzheimer’s or Dementia

**Yes / No** Fainting, Seizures, Epilepsy **Yes / No**  Thyroid Problems **Yes / No** Auto-Immune Disease

**Yes / No** Persistent Cough **Yes / No**  Cancer/Tumor **Yes / No**  Diabetes

**Yes / No** Hepatitis, Jaundice, Liver **Yes / No** Thirsty / Dry Mouth Often **Yes / No**  Family History of Diabetes

**Yes / No**  Tuberculosis / Respiratory **Yes / No** Swollen Glands **Yes / No**  Smoke, Vape, Tobacco

**Yes / No** HIV Positive or AIDS **Yes / No** Herpes or Cold Sores **Yes / No**  History of Drug / Alcohol Abuse

**Yes / No**  Are you under a drug contract

**Women:**

**Yes / No** Are you taking contraceptives or other hormones?

**Yes / No** Are you pregnant?

**Yes / No** Are you nursing?

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

**Yes / No** Local anesthetic (“Novocaine”)  **Yes / No**  Aspirin, Acetaminophen or Ibuprofen

**Yes / No**  Penicillin, Sulfa or other Antibiotics **Yes / No** Codeine, Demerol or other Narcotics

**Yes / No** Barbiturates, Sedatives or Sleeping Pills **Yes / No** Reaction to metals

**Yes / No** Latex or Rubber Dam

**Yes / No** Other Allergies? Please Explain:

**Dental History**

Do you want complete Dental care? **Yes / No** Do you clench or grind your teeth frequently? **Yes / No**

Are you apprehensive about dental treatment?  **Yes / No** Do you have jaw pain or headaches in the morning?  **Yes / No**

Do you gag easily? **Yes / No** Do you have difficulty chewing your food? **Yes / No**

Do your gums bleed easily?  **Yes / No** Do you have TMJ/TMD (jaw) disorder? **Yes / No**

Are you teeth sensitive? **Yes / No** Do you have pain in the face, cheeks, joints,

Are you dissatisfied with the appearance of your teeth? **Yes / No** throat or temples?  **Yes / No**

Have you had a blow to the jaw (trauma)? **Yes / No**

**Patient (Parent/Legal Guardian) Signature: Date: Dr/Hyg Initals:**

**FOR FUTURE UPDATES**

**Update:** I have reviewed my medical history and made any changes?

1. Date: Patient Initials Dr/Hyg Initials 2. Date: Patient Initials Dr/Hyg Initials

***GRANITE FALLS DENTAL CARE***

**Financial Policy**

**Payment at time of service**

We require payment at the time of service. For your convenience we accept Visa, MasterCard, Discover,

Checks, and Cash. Also offered is an interest free and low monthly payment option through Care Credit™, a

third party lending company. We are happy to assist you with any of these payment plan options, just ask!

**These options are only for those patients who do not have PPO Dental Benefits.**

**Insurance and Insurance Co-payment Responsibility**

Full payment of your account is your responsibility. We will file your insurance claims on your behalf as a

courtesy to you, provided your dental insurance company will assign benefits directly to us. Having dental insurance

is not a guarantee of payment. Your insurance coverage is a contract that is set up between your employer and the

insurance company. We can only guarantee our fees and **ESTIMATE** your dental benefits. We ask that you review

all estimates and call your insurance company with any questions.

You will be asked to pay your insurance copayment at the time of service. Your copayment is the dollar amount

that is estimated as not payable by your dental insurance plan. If payment for completed treatment is not paid

by your dental insurance company within 90 days, we reserve the right to request payment in full for the balance

owing on your account. When your insurance company eventually pays, we will gladly refund the difference to you.

**Returned Check Fee**

Accounts will be charged a $35 fee for any checks returned by the bank as well as any stop payments that are

issued on checks or credit card payments.

**Finance Charges**

Finance charges accrue on the unpaid balance beginning on the 90th day after charges are incurred. The interest

rate will be 18% per annum or the maximum allowable according to state law. In the event the account is referred

to collections, the undersigned, or the agent, will be responsible for payment of interest on the unpaid balance

at 1% per month from the date of service, in addition to collection fees, reasonable attorney fees and court costs.

**Broken Appointment Fee**

We request 48 hours notice to change an appointment. A charge may be applied to your account in the amount

of $100 per hour if an appointment is changed with less than 48 hours notice, or if you fail to keep your

scheduled appointment.

*I hereby acknowledge receipt of the above information and understand that I am completely responsible*

*for the total payment of all procedures performed.*

Printed Name Patient/Parent/Legal Guardian Signature Date

**HIPPA PRIVACY PRACTICE:**

**I have received and read the HIPPA Privacy Practice**

**Patient (Parent/Legal Guardian) Signature: Date:**