

the GRAPEVINE
DENTIST

Because everyone deserves to smile!

PATIENT INFORMATION

Patient's Name _____ Birthdate _____ SS# _____

Marital Status _____ Drivers License # _____ State _____

Home Phone _____ Work Phone _____ Cell Phone _____

Mailing Address _____ City _____ State _____ Zip _____

Email _____

Employer _____ Occupation _____

Whom may we thank for referring you to our office? _____

Are you currently under the care of a dental provider (i.e. general dentist, orthodontist, etc.)? no yes

If yes, please indicate provider name: _____

Is an immediate family member a patient here? no yes Name: _____

May we contact you regarding upcoming appointments, reminders, or office specials via Email and/or Text Message

INSURANCE INFORMATION: Not covered by dental insurance

Insured Name _____ Insured Date of Birth _____

Insured Employer _____

Insured ID or Social Security # _____ Dental Insurance Co _____

Group Number _____ Phone Number _____

PHARMACY INFORMATION:

Name _____ Have you filled here before: ? no yes

Pharmacy Address _____

City _____ Zip _____ State _____

Pharmacy Phone Number _____

EMERGENCY CONTACT INFORMATION:

Name AND Relation _____

Home Phone _____ Cell Phone _____

Address _____ City _____ Zip _____ State _____

Patient's Signature: _____ Date: _____

Parent/Guardian (if patient is a minor): _____

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MEDICAL HEALTH HISTORY

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

- | | | |
|-----------------------------|------------------------------|----------------------------------|
| <input type="checkbox"/> no | <input type="checkbox"/> yes | AIDS/HIV Postive |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Allergies or Hives |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Anemia |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Angina Pectoris |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Arthritis |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Artificial Joint or Heart Valve |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Asthma |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Blood Tranfusion |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Bruise Easily |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Chemotherapy |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Cold Sores/Fever Blisters |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Congenital Heart Defects/Lesions |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Cortisone Medicine |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Cough |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Diabetes |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Emphysema |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Epilepsy/Seizures |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Fainting/Dizzy Spells |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Glaucoma |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Heart Attack/Disease |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Heart Failure |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Heart Murmur |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Heart Surgery |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Hepatitis A or B |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | High/Low Blood Pressure |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Kidney Trouble |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Liver Disease |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Mitral Valve Prolapse |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Pace Maker/Defibrillator |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Psychiatric Treatment |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Radiation Treatment |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Rheumatism |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Sleep Apnea |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Sickle Cell Disease/Traits |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Stroke |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | STD or VD |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Thyroid Disease |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Tuberculosis |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Ulcers/Colitis |

Other: _____

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

- | | | |
|-----------------------------|------------------------------|--|
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Latex materials |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Penicillin or other antibiotics |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Local anesthetics ("Novocain") |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Codeine or other narcotics |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Sulfa drugs |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Barbiturates, sedatives, or sleeping pills |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Aspirin |

Other: _____

Are you taking any of the following?

- | | | |
|-----------------------------|------------------------------|--|
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Anticoagulants (blood thinners) |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Antibiotics or sulfa drugs |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | High blood pressure medicine |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Antidepressants or tranquilizers |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Insulin, Orinase, or other diabetes drug |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Nitroglycerin |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Cortisone or other steroids |
| <input type="checkbox"/> no | <input type="checkbox"/> yes | Osteoporosis (bone density) medicine |

Please list **ALL** current medications you are taking to include vitamins and supplements:

Have you or do you currently smoke and/or vape?

***This information is important for your safety during surgery.**

no yes

Have you or do you currently use illicit drugs?

***This information is important for your safety during surgery.**

no yes

Women:

no yes May be pregnant

no yes Taking hormones or contraceptives

Have you been hospitalized or had a serious operation or illness within the last five years? no yes

Do you have any disease, condition, or problem not listed above? _____

CONSENT: I _____, authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the Patient and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

Patient's Signature: _____

Date: _____

Parent/Guardian (if patient is a minor): _____

Relationship To Patient: _____



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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, filing insurance, and health care operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. Please note, you may obtain a copy of our Notice at any time.

The Grapevine Dentist

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

Patient's Name: _____ Date: _____

Please list person(s) we can release information to on your behalf:

Patient's Signature

-OR-

Signature of Personal Representative: _____ Date: _____

Description of Personal Representative (i.e. Power of Attorney, Parent, Gurdian, Other): _____

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Office Policies

Insurance Policy:

The Grapevine Dentist is in-network with all major PPO insurance companies.

Upon verifying your benefits, we will provide an estimate prior to your treatment. Please note, it is not guaranteed that your insurance will cover the treatment as estimated.

In the event you have limited coverage, you will be responsible for any charges and/or fees billed to your insurance company where payment is denied.

Primary and Secondary Insurance:

- The Grapevine Dentist will verify both primary and secondary insurance.
- Your primary insurance will apply at the time of treatment. We cannot show estimated coverage with your secondary insurance until we bill the primary insurance.
- The Grapevine Dentist will bill your primary insurance for treatment.
- **Once we receive the EOB back from your primary, we will bill your secondary. Secondary insurance requires an EOB (explanation of benefits) from the primary insurance before a claim can be sent.**

Predeterminations:

- A predetermination (pre-d) of benefits is a review by your insurer's dental staff, to determine if they agree with your treatment that we have recommended for your dental needs.
- **Predeterminations are done prior to your treatment, to ensure you understand what is covered vs what is not covered by your dental insurance plan.**
- Patient initial: _____

Payment Policy:

For your convenience, The Grapevine Dentist accepts that following forms of payment:

- Debit cards
- All major credit cards (Visa, Master Card, and American Express)
- Care Credit
- Lending Club
- Check
 - **Please note, The Grapevine Dentist must receive all checks AT LEAST 5 business days prior to your treatment. The Grapevine Dentist requires the FULL amount to clear the bank prior to the date of your treatment.**
- Patient Initial: _____

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Deposit Policy:

The Grapevine Dentist will collect the following deposits upon scheduling your dental treatment. Please note, all deposits will go towards your total treatment amount.

- o Implants: \$200
- o Wisdom teeth: \$200
- o SRP (deep cleaning): \$50
- o Crowns: \$50
- o Zoom Whitening: \$100
- o Sedation for general dentistry treatment \$200
- o Tissue Graft: \$200
- o Osseous: \$200
- o LANAP: \$200

- Patient initial: _____

Rescheduling Policy:

- Rescheduling your dental appointment less than 48 hours in advance, is subject to the following nonrefundable office fees.
 - o Rescheduling one time = \$50
 - o Rescheduling two times = \$100
 - o Rescheduling three times = The Grapevine Dentist will no longer accept you as patient
- Rescheduling a surgery (i.e. wisdom teeth, implants, extractions, etc.) less than 7 calendar days in advance, is subject to the following office fees.
 - o 7 calendar days or less = \$200 **nonrefundable office fee**
- Patient initial: _____

Late Patient Policy

- Patients who arrive more than fifteen (15) minutes late to their scheduled appointment time may be asked to reschedule as a courtesy to our other scheduled patients.
- Patient initial: _____

I, _____ have read, understand, and agree to The Grapevine Dentist's Insurance Policy, Payment Policy, Deposit Policy, and Rescheduling Policy. I understand failure to abide by these office policies could result in cancelation of my treatment and procedure.

Patient Signature: _____

Date: _____

Parent/Guardian Signature (minor patients): _____

Radiograph Scan and Scope of Review Acknowledgement

The Grapevine Dentist offers a complimentary radiographic or 3-D image scan (CBCT scan) of your jaw.

Radiation:

- Radiographic scans such as x-rays, CT scans, etc. expose you to radiation. All radiation exposure is linked with a slightly higher risk of developing cancer. The level of risk depends on the total amount of radiation received. The amount of radiation you will be receiving during this scan, is set to be the lowest as reasonably achievable.
- The scans are NOT recommended for pregnant women due to the potential danger the fetus.
- Declining a CBCT scan will result in preventing adequate ability to diagnose you. Since a CBCT scan is a diagnostic tool, lack of information will require further evaluation and treatment planning.
- Patient initial: _____

Limited Review of the Scan:

- An authorized physician at The Grapevine Dentist will interpret the scan for potential dental procedures ONLY.
- The scan will not be reviewed by a radiology specialist.
- A physician at The Grapevine Dentist will not review, interpret, and/or analyze the scan for medical issues and/or concerns.
- Patient initial: _____

No Treatment Relationship:

- This CBCT scan does not create a treatment relationship with the physicians at The Grapevine Dentist.
- This CBCT scan does not create an obligation for The Grapevine Dentist to perform your treatment.
- A treatment relationship will begin after your initial consultation and exam at The Grapevine Dentist.
- Patient initial: _____

I, _____ have read, understand, and agree to the Radiographic Scan and Scope of Review Acknowledgement and understand I have been informed of the risk and benefits of having the scan.

Patient Signature: _____

Date: _____

Parent/Guardian Signature (minor patients): _____