the GRAPEVINE DENTIST

Because everyone deserves to smile!

# PATIENT INFORMATION

Patient's Name _____ Birthdate _____ SS#_____

Marital Status _____ Drivers License #_____ State _____

Home Phone_____ Cell Phone _____

Mailing Address _____ City _____State _____ Zip _____

Email _____

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

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**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 _____

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**PHARMACY INFORMATION:**

Name _____ Have you filled here before: ? ❑ no ❑ yes

Pharmacy Address _____ City _____ Zip _____ State _____

Pharmacy Phone Number _____

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**EMERGENCY CONTACT INFORMATION:**

Name: _____ Relation: _____

Contact Phone Number: _____

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**HOW WOULD YOU LIKE TO IMPROVE YOUR SMILE?**

❑ Whitening ❑ Straightening ❑ Better overall oral hygiene ❑ Veneers ❑ I like my smile the way it is

Other:_____

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?

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

❑ Other: _____

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

| | | |
|---|---|---|
| ❑ no | ❑ yes | Latex materials |
| ❑ no | ❑ yes | Penicillin or other antibiotics |
| ❑ no | ❑ yes | Local anesthetics ("Novocain") |
| ❑ no | ❑ yes | Codeine or other narcotics |
| ❑ no | ❑ yes | Sulfa drugs |
| ❑ no | ❑ yes | Aspirin |
| ❑ no | ❑ yes | Barbiturates, sedatives, or sleeping pills |

Other: _____

Are you taking any of the following?

| | | |
|---|---|---|
| ❑ no | ❑ yes | Anticoagulants (blood thinners) |
| ❑ no | ❑ yes | Antibiotics or sulfa drugs |
| ❑ no | ❑ yes | High blood pressure medicine |
| ❑ no | ❑ yes | Antidepressants or tranquilizers |
| ❑ no | ❑ yes | Insulin, Orinase, or other diabetes drug |
| ❑ no | ❑ yes | Nitroglycerin |
| ❑ no | ❑ yes | Cortisone or other steroids |
| ❑ no | ❑ 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 or vape or use tobacco products?
***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/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: _____

**PRINT Patient's Name:** _____

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 (medical or financial) to on your behalf:

_____

_____

_____
Patient's Signature (must sign even if you do not list anyone)

**-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 Insurances:**

- The Grapevine Dentist will verify both primary and secondary insurance.
- Your primary insurance will apply at the time of the 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 (explanation of benefits) back from your primary, we will bill your secondary. Secondary insurance requires an EOB 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 the following forms of payment:

- Debit Cards
- All major credit cards (Visa, Master Card, and American Express)
- Care Credit
- Lending Club
- Possible Payment Plans - ANY DENIED PAYMENTS WILL HAVE AN ADDITIONAL FEE OF $150 ADDED TO YOUR BALANCE - AFTER 2 DENIED PAYMENTS, YOU WILL BE SENT TO COLLECTIONS
- 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.

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

Patient Initial _____

**Rescheduling Policy:**

- Rescheduling your dental appointment *less than 48 hours in advance* is subject to the following nonrefundable office fees:
  - Rescheduling *one* time: $50
  - Rescheduling *two* times: $100
  - Rescheduling *three* times: The Grapevine Dentist will no longer accept you as a 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.
  - 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 that failure to abide by these office policies could result in cancelation of my treatment and procedure.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (minor patients): _____

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# Radiograph Scan and Scope of Review Acknowledgement

The Grapevine Dentist offers a complimentary radiographic or 3D 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 to 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): _____