the GRAPEVINE DENTIST

Because everyone deserves to smile!

PATIENT INFORMATION

Patient's Name _____ Birthdate _____ SS#_____

Marital Status _____ 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

---

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: _____ Relation: _____

Contact Phone Number: _____

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):* _____

the GRAPEVINE DENTIST

Because everyone deserves to smile!

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	Anxiety
❑ no	❑ yes	Arthritis
❑ no	❑ yes	Artificial Joint or Heart Valve
❑ no	❑ yes	Asthma
❑ no	❑ yes	Autoimmune Disorder
❑ 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	Cough (persistent)
❑ no	❑ yes	Diabetes: Type 1/Type 2 A1C:____
❑ no	❑ yes	Emphysema
❑ no	❑ yes	Epilepsy/Seizures
❑ no	❑ yes	Fainting/Dizzy Spells
❑ no	❑ yes	Gastric Bypass
❑ 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 or C
❑ no	❑ yes	High/Low Blood Pressure
❑ no	❑ yes	Kidney Trouble
❑ no	❑ yes	Liver Disease
❑ no	❑ yes	Mitral Valve Prolapse
❑ no	❑ yes	Osteoporosis
❑ 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/TIA
❑ 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	**Barbiturates, sedatives, or sleeping aides**.
❑ no	❑ yes	**Aspirin**

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 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. Continue to back if needed.

_____

_____

***The following information is important for your safety during surgery:**

Alcohol Usage:

❑ Daily ❑ Weekly ❑ Socially ❑ Occasionally

Have you or do you currently smoke or vape or use tobacco products?

❑ no ❑ yes

Have you or do you currently use illicit drugs?

❑ no ❑ yes

If yes, what_____

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: _____

PRINT Patient's Name: _____

Parent/Guardian *(if patient is a minor):* _____ Relationship to Patient: _____

the GRAPEVINE DENTIST

Because everyone deserves to smile!

MEDICAL HEALTH HISTORY CONTINUED

If you have marked "No" to any of the following medical conditions on the previous page, you may leave this page blank.

If you have marked "Yes" to any of the following medical conditions on the previous page:

- AUTOIMMUNE DISEASE
- GASTRIC BYPASS
- PREGNANT
- RADIATION TREATMENT/ CHEMOTHERAPY
- STROKE/TIA
- ANY HEART RELATED ISSUES (SUCH AS HEART ATTACK/DISEASE, HEART FAILURE, HEART MURMUR, HEART SURGERY, DEFIBRILLATOR, AND PACEMAKER)

PLEASE BE AS DETAILED AS POSSIBLE. FOR EXAMPLE, THE DATE & YEAR, EXTREME DETAIL ABOUT THE CONDITION, ETC.

_____

_____

_____

_____

NEUROLOGIST INFORMATION (REQUIRED):

DOCTOR: _____

PHONE: _____

FAX: _____

CARDIOLOGIST AND/OR ELECTROPHYSIOLOGIST INFORMATION (REQUIRED):

DOCTOR: _____

PHONE: _____

FAX: _____

ONCOLOGIST INFORMATION (REQUIRED):

DOCTOR: _____

PHONE: _____

FAX: _____

RHEUMATOLOGIST INFORMATION (REQUIRED):

DOCTOR: _____

PHONE: _____

FAX: _____

OBGYN INFORMATION (REQUIRED)

DOCTOR: _____

PHONE: _____

FAX: _____

the GRAPEVINE DENTIST

Because everyone deserves to smile!

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): _____

the GRAPEVINE DENTIST

Because everyone deserves to smile!

Office Policies for The Grapevine Dentist and North Texas Dental Surgery

Insurance Policy:

The Grapevine Dentist/North Texas Dental Surgery 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. **Please provide your dental insurance prior to your appointment.**

Primary and Secondary Insurance:

- We 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.

Predetermination/Pre-Estimates:

- A predetermination/pre-estimate (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.
- Predetermination/pre-estimates are sent prior to your treatment, to ensure you understand what is covered vs what is not covered by your dental insurance plan.
- Predetermination/pre-estimates are just an **ESTIMATE**. Even if your insurance "approves" a Pre-D, they can still deny treatment after completion.

Payment Policy:

For your convenience, we accept that following forms of payment:

- Debit cards
- All major credit cards (Visa, Master Card, and American Express)
- Care Credit
- Cash
- 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: _____

the GRAPEVINE DENTIST

Because everyone deserves to smile!

Deposit Policy:

We 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
- Sedation for general dentistry treatment $200
- Tissue Graft: $200
- Osseous: $200
- LANAP: $200

Rescheduling/Cancellation Policy:

Your time is important to us, and to ensure we honor both your schedule and that of our providers, please confirm your appointment by replying to our messages. If you need to reschedule your appointment for any reason, please let us know as soon as possible, as our schedule is typically at capacity. To respect our providers' time:

- Any appointments ***not confirmed within 24 hours of the scheduled appointment time*** will be released and offered to patients on our waitlist.
- Rescheduling/cancelling your confirmed dental appointment ***less than 48 hours in advance*** OR missing your confirmed scheduled appointment, is subject to the following nonrefundable office fees:
  - Rescheduling *one time* =$50
  - Rescheduling *two times* = $100
  - *No call no show* = $100
  - Rescheduling *three times* = The Grapevine Dentist will no longer accept you as patient

- Rescheduling an appointment with North Texas Dental Surgery (Dr Choi) or a Sedation Appointment (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**
  - Rescheduling the day of = payment in full

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: _____

the GRAPEVINE DENTIST

Because everyone deserves to smile!

I, _____ have read, understand, and agree to The Grapevine Dentist/North Texas Dental Surgery's Insurance Policy, Payment Policy, Deposit Policy, and Rescheduling/Cancellation Policy. I understand that failure to abide by these office policies could result in cancellation of my treatment, procedure, and possible dismissal. **I also understand that as an independent organization, The Grapevine Dentist and North Texas Dental Surgery reserve the right to dismiss me as a patient or refuse services at any point of the treatment. Reasons for dismissal include but are not limited to: patient's continuous negligence to protocol, patient disrespect or harm to doctors and/or staff, etc.**

Patient Signature: _____ Date: _____

Parent/Guardian Signature (minor patients): _____

Patient Initial: _____

the GRAPEVINE DENTIST

Because everyone deserves to smile!

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 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.*

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.

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.

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): _____

 Patient Initial: _____