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 to our office or how did you hear about us? __________________________

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)*: ____

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MEDICAL HEALTH HISTORY

Patient Name ___________________________________

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

❑ no ❑ yes **AIDS/HIV** Positive
❑ 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: ___________________________________

Height: _______________ Weight: _____________

Women:

❑ no ❑ yes May be pregnant
❑ no ❑ yes Taking hormones or contraceptives.

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 aides.**

Other: ___________________________________

****Do you need to pre-medicate before any procedure due to an artificial joint (i.e. hip/knee replacement)?**

❑ no ❑ yes

Are you taking any of the following?

❑ no ❑ yes Anticoagulants (blood thinners)
❑ no ❑ yes Antiresorptive (i.e Fosamax, Actonel, Zometa, Boniva, Reclast, Aredia, Xgeva)
❑ no ❑ yes Antibiotics or sulfa drugs
❑ no ❑ yes High blood pressure medicine
❑ no ❑ yes Antidepressants or tranquilizers
❑ no ❑ yes Cancer medications (i.e Sutent,Nexavar, Avastin, Rapamune, Zolendronate)
❑ no ❑ yes Insulin or other diabetes drug
❑ no ❑ yes Nitroglycerin
❑ no ❑ yes Cortisone or other steroids
❑ no ❑ yes Osteoporosis (bone density) medicine
❑ no ❑ yes Have you ever taken Phen-Fen/Redux? (for weight loss)
❑ no ❑ yes Have you ever taken bisphosphonates (Fosamax, Actonel)?

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

Alcohol Usage: ❑ NONE ❑ Quit

How long ago? _______________________

❑ Daily ❑ Weekly ❑ Socially ❑ Occasionally

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

❑ no ❑ yes ❑ never ❑ Quit

How long ago? _______________________

❑ Daily ❑ Weekly ❑ Socially ❑ Occasionally

Have you or do you currently use illicit drugs?

❑ no ❑ yes ❑ Quit How long ago? _________

❑ Daily ❑ Weekly ❑ Socially ❑ Occasionally

If yes, what_______________________________

Do you have a history of drug abuse? ❑ no ❑ yes

☐Alcohol ☐Meth ☐MJ ☐Cocaine ☐Opioids ☐Other

Are you under the care of a pain management physician?

❑ no ❑ yes

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MEDICAL HEALTH HISTORY CONTINUED Patient Name ______________________________

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: ______________________________

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MEDICAL HEALTH HISTORY CONTINUED ________ Patient Name ____

Please list ALL the current medications you are taking to include vitamins and supplements.

❑ NONE

____

____

____

____

____

____

____

____

____

Have you been hospitalized and/or had a serious operation or illness within the last five years? ❑ no ❑ yes Do you have any disease, conditions, or problems 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 it. I also understand that 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 with Patient: ____

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.

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): ________________________

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) / tap to pay / Apple Pay
- 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: ______________

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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 or Extractions w/BG: $200
- SRP (deep cleaning): $50
- Crowns: $150
- 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/Cancelling one time =$50
    - Rescheduling/Cancelling two times = $100
    - No call no show = $100
    - Rescheduling/Cancelling 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: ______________

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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: ___________

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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: _____________