Grand Dental P.C.

Grand Dental, P.C.
1035 Grand Avenue
Grand Junction, CO 81501

(970) 243-8580
office@mygranddental.com
www.myGrandDental.com

PATIENT INFORMATION

Patient Name: _____ Preferred Name/Nickname: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____
Birth Date: _____ Social Security #: _____ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Child ☐
Employer: _____ Occupation: _____
Spouse/Parent Name: _____ Relationship: _____
Whom may we thank for referring you? _____

INSURANCE INFORMATION

Insurance Holder's Name: _____ Relationship to patient: _____ Birth Date: _____
Social Security #: _____ Work Phone: _____ Employer's Name: _____
Insurance Company Name: _____ Group Number: _____ Phone Number: _____
Other Dental Insurance: _____ Date of Last Treatment: _____
Reason for today's visit: _____

PAYMENT IS DUE AT THE TIME OF SERVICE

Cash/Personal Check/Money Orders (There is a returned check fee of $30 for insufficient funds).

DENTAL INSURANCE

We will submit your insurance as a courtesy to assist you in obtaining the benefit due. We will be happy to help you file and collect payment but are not responsible for insurance payment or denial. Estimates given are not guaranteed. You agree to be accountable for all fees incurred regardless of insurance coverage.

TREATMENT AUTHORIZATION & ACKNOWLEDGEMENT

I hereby authorize the doctor to perform any and all forms of treatment necessary in connection with my dental care and further consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, a full explanation of the procedure(s) will be given by the doctor or his staff. I agree to pay for all services rendered by this office and authorize my insurance company to release payment to Grand Dental P.C. All outstanding balances over 60 days are subject to an interest rate charge of 1.5%/month (18%). I understand that should my account become delinquent, my information may be released to a third party collection agency. I agree to be responsible for all fees ,interest and legal expenses associated with collection of my account.

I have read and understand the above information for Grand Dental P.C. My signature is my acknowledgement and agreement of these policies.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarded by protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment, and follow-up, among the multiple health care providers who may be involved in treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received, or read, your HIPAA containing a more complete description of the uses and disclosures of my information. I understand Grand Dental has the right to change its HIPAA from time to time and that I may contact them at any time to obtain a current copy. I understand that I may request, in writing, that you restrict how my private information is used to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by those restrictions.

Signature: _____ Date: _____

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MEDICAL HISTORY

Patient Name: _____

1. Have you been a patient in a hospital during the past two years? Yes ☐ No ☐
   If yes, for what reason?
2. Have you been under the care of a medical doctor the past two years? Yes ☐ No ☐
   If yes, for what reason? _____
3. Primary Health Care Providers Name: _____ Phone Number: _____
4. Are you currently taking or taken in the past two years any prescription or nonprescription drugs? Please list:

Drug	Dose/Frequency	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Do you have any allergies or are you made sick by metals,Jewelry,aspirin,penicillin,codeine, or any other drugs, food or medication? Yes ☐ No ☐
   If yes, please list: _____
6. Have you ever had excessive bleeding requiring special treatment? Yes ☐ No ☐
7. When you walk or use the stairs do you ever have to stop due to chest pain? Yes ☐ No ☐
8. Do you use more than 2 pillows to sleep with? Yes ☐ No ☐
9. Are you on a special diet? Yes ☐ No ☐
10. Do you use tobacco products? Yes ☐ No ☐
    If yes, what kind? _____
11. Do you drink alcoholic beverages? Yes ☐ No ☐
12. Do you use recreational /street drugs? Yes ☐ No ☐
13. ***Women only:*** Are you pregnant? Yes ☐ No ☐
14. ***Women only:*** Are you taking prescription contraceptives? Yes ☐ No ☐

CIRCLE THE FOLLOWING THAT YOU HAVE NOW OR HAVE HAD:

Allergies/Asthma/Hives/Hay fever	Anemia/Hemophilia/Sickle cell disease	Arthritis/glaucoma
Angina Pectoris(chest pain)/Pacemaker	Artificial heart valve/joints	Blood disease/transfusion
Diabetes/Bruise easily	Chemotherapy/radiation treatment	Congenital heart lesion/murmur
Cold sores/blisters	Emphysema/Shortness of breath	Epilepsy/Seizures/Head injuries
Fainting/Dizzy spells	Heart Disease/Failure/Stroke	Hepatitis/HIV/AIDS
High blood pressure/Irregular heartbeat	Jaundice/Kidney or liver disease	Mental/Nervous Disorder
Psychiatric treatment/Drug Addiction	Respiratory problems/Tuberculosis	Rheumatic fever
Sinus/Thyroid problem	Stomach problems/ulcers	Tumors/Cancer

To the best of my knowledge, every question is answered completely and accurately. I will inform staff of any changes.

Signatrue: _____ Date: _____