vPatient Registration and Medical History

DATE: _____

HOME PHONE: _____

CELL PHONE: _____

MAY WE CONTACT YOU VIA TEXT? ☐ **YES** ☐ **NO**

EMAIL: _____

****Primary Language:** ENGLISH / SPANISH

WHO MAY WE THANK FOR REFFERING YOU? ☐ **GOOGLE** ☐ **BILLBOARD** ☐ **INSURANCE** ☐ **OTHER** _____

☐ **MUTUAL PATIENT NAME:** _____

Patient Information

PATIENT NAME: _____ **PREFERRED NAME:** _____

STREET ADDRESS: _____ **CITY:** _____ **ST:** _____ **ZIP:** _____

SEX: _____ **M** _____ **F** **AGE:** _____ **DATE OF BIRTH:** _____ **Single:** _____ **Married:** _____

SSN: _____

Account Information

Who is responsible for this account? _____ **Relation to Patient:** _____

Spouse/Parent Name: _____ **Birthdate:** _____

Spouse/Parent SSN: _____ **Name of Insured:** _____ **Relation to Patient:** _____

Medical History

When was you last dental visit? What treatment did you receive? _____

Who should we call in case of an emergency? _____ **Phone #:** _____

Physician's Name: _____ **Last Physical:** _____

Do you need Pre-Medication? _____ **Are you taking any medications at this time?** _____

Are you under the care of physician? Why? _____

Do you suspect that you may be pregnant? _____ **Due Date:** _____ **Are you taking birth control?** _____

Have you ever had any of the following? (CHECK ALL EITHER YES OR NO)

Y	N		Y	N		Y	N		Y	N		
☐	☐	Artificial Heart Valve	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Thyroid Problems	List of Medications
☐	☐	Anemia	☐	☐	Excessive Bleeding	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers	
☐	☐	Artificial Joints	☐	☐	Headaches	☐	☐	Mental Disorders	☐	☐	Venereal Disease	
☐	☐	Asthma	☐	☐	Head Injuries	☐	☐	Pacemaker	☐	☐	General Allergies	
☐	☐	Blood Disease	☐	☐	Heart Disease	☐	☐	Psychiatric Care	☐	☐	Allergic to Anesthetic	
☐	☐	Blood Thinners	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Allergic to Latex	
☐	☐	Cancer	☐	☐	Hemophilia	☐	☐	Respiratory Problems	☐	☐	Allergic to Medicine	
☐	☐	Circulatory	☐	☐	Hepatitis	☐	☐	Rheumatic Fever	☐	☐	Allergic to Penicillin	
☐	☐	Chemical Dependency	☐	☐	High Blood Pressure	☐	☐	Sinus Problems	☐	☐	Allergic to Tetracycline	
☐	☐	Diabetes	☐	☐	HIV/AIDS	☐	☐	Stroke	☐	☐	History of Tobacco Use	
☐	☐	Dizziness	☐	☐	Jaundice	☐	☐	Swollen Neck Glands	☐	☐	History of Osteoporosis	

Conditions not listed above _____

The above information is accurate and complete to the best of my knowledge. Since a change in medical condition or medication can affect dental treatment, I will inform the office of any changes at any subsequent appointment. I will not hold the dentist or any member of his/her staff responsible for any error of omissions that I might have in completing this for.

_____ _____ _____ _____

Signature of Patient/ Legal Guardian Date Doctor's Signature Date

GRACE FAMILY DENTISTRY
HIPAA CONSENT FORM

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____
Address: _____
Telephone: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this from you will consent to our use and disclosure of you protected health information to carry out treatment, payment activities and healthcare operations.

Notice of privacy practices: 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 payment activities and health operation, of the use 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 reserve the right to change our privacy practice as described in our Notice of privacy practices. Those changes may apply to any of our protected health information that we maintain.
Right to revoke: you have the right to revoke this consent at any time by giving us written notice to the extent the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

SECTION C: SIGNATURE

I, _____ have had the full opportunity to read and consider the content of this consent from and notice of privacy practices, I understand that by signing this consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment and health care operations.

Signature: _____
Relation to patient: (self, parent, others)

Grace Family Dentistry

2888 Browns Bridge Rd., Suite C
Gainesville, Georgia 30504
Telephone: (770)532-1111

Financial Policy

It is our policy to provide an "estimate" of necessary treatment. The estimated fees will be honored for up to one year from the estimate date. This will enable you to know what services are planned, as well as, what your financial responsibility will be. Our financial policy is as follows:

Payment: We request that full payment be made at the time of appointment. We accept cash, personal checks, Visa, Master Card and Discover.

Insurance: Please keep in mind that **ALL** dental costs remain the responsibility of the patient and that not all dental costs are covered by insurance. If you have dental insurance, as a courtesy, we will be glad to assist you in filing your insurance claim.
We encourage **ALL** patients to review their dental benefits and communicate directly with their insurance provider.

Aseguranza: Por favor, tenga en cuenta que **TODOS** los gastos dentales siguen siendo responsabilidad del paciente y que no todos los costos dentales están cubiertos por el seguro. Si usted tiene seguro dental, como una cortesía, estaremos encantados de ayudarle a presentar su reclamación de seguro. Animamos a **TODOS** los pacientes para revisar sus beneficios dentales y nos comunicamos directamente con su proveedor de seguros.

Broken Appointment Charge: Your appointment time is reserved exclusively for you. We realize that unforeseen circumstances befall its all. However, we do require a **48 hour notice** to avoid a broken appointment charge. Although the office does attempt to make courtesy reminder calls regarding your appointments we consider these appointments to be your responsibility.

Cargo de Cancelación: Su hora de la cita está reservada exclusivamente para usted. Nos damos cuenta de que circunstancias imprevistas acaecen. Sin embargo, requerimos **48 horas de anticipación** para evitar un cargo por no avisar un cambio a su cita o cancelación. Aunque la oficina no intentará realizar llamadas de recordatorio de cortesía con respecto a sus citas, consideramos estos nombramientos a ser su responsabilidad.

Mon. - Fri. Broken Appointment Fee:	$65.00
Saturday Broken Appointment Fee:	$80.00

Collections: If account is sent to collections for non-payment, patient (or Head of Household) will be responsible for remaining balance and collection fees.

Colecciones: Si la cuenta se envía colecciones por falta de pago, el paciente (o cabeza de familia) será responsable de mantenerse el equilibrio y la recolección de impuestos.

I have read the financial policy and understand the said terms regarding payment for services, insurance and broken appointment charges.

Patient Signature: _____ Date: _____