Date: _____

PATIENT REGISTRATION

Patient Name: _____ Prefers to be called: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

E-Mail Address:_____

Birthdate: _____ Age: _____ Social Security Number: _____

Patient's Employer: _____

Male: ____ Female: ____ Child: ____ Married: ____ Single: ____ Divorced: ____ Widowed: ____

Spouse: _____ *Occupation:*_____ *Employer:* _____

Responsible Party (If other than patient) _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Birthdate: _____ Age: _____ Social Security Number: _____

Dental Insurance Information

Employer:_____

Subscriber (Employee):_____
Birthday: _____

Primary Insurance Company:

_____

Group Number:_____

Social Security Number: _____

Member ID: _____

Secondary Insurance Company:

_____

Employer:_____

Subscriber:_____

Member ID:_____

Group Number: _____

Whom may we thank for referring you to our office?

Is Another Member of your family a Patient of our office?

Name: _____ Relationship:

Whom may we contact in case of emergency?

Name: _____ Relationship:

Address:

_____

Phone Number:

_____

Closest Relative Not Living with you.

Name:

_____

Address:

_____

Phone Number:

_____

Name:_____

Phone Number:_____

Dental History

Patient Name_____

Medical Alert_____

Welcome! So that we may provide you with the best possible care please complete
both **sides of this dental/medical history form. All information is completely confidential.**

What is the reason for your visit today? _____

Date of: Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name_____
Address_____ City_____ State_____ Zip _____
Telephone _____ **Reason for leaving** _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? (Oral B, toothpick, etc.) _____

Do you have any dental problems now? Yes No
If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odor or bad tastes?	Yes	No
Do you or anyone in your family have a history of oral cancer?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Your teeth ground or the bite adjusted	Yes	No
A serious injury to the mouth or head? If so, please describe, including cause _____ _____	Yes	No

Have you experienced:

Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where? _____		
Do you: _____	Yes	No
	Yes	No
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?		
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No
If so how much? _____	Yes	No

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing mouth?	Yes	No
Difficulty in chewing on either side of your mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No

Do you:

Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment? If so, what's your main concern _____	Yes	No

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes please describe. _____
_____

Patient Name_____ **Medical History**

Medical Doctor's Name _____ Phone _____
Address _____ City _____ State _____ Zip _____

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
2. Have you taken any medication or drugs during the past two years? _____ Yes No
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the counter herbal medicines?..... Yes No
   If yes, please list name and dosage _____
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen, Pondimen, and Redux?..... Yes No
   If yes to the above, did you have a medical exam for heart issues?..... Yes No
5. Have you ever been treated for metastic bone cancer?..... Yes No
6. Have you ever been treated with the following drugs for osteoporosis or metastic bone cancer? Please circle any that apply. *Any dental procedures performed including but not limited to extractions, endodontics, orthodontics and any surgical procedure may cause bone and/or infection complications including bone necrosis as a result of these medications.*

Etidronate (Didronel)	Ibandronate (Boniva)	Pamidronate IV	Alendronate (Fosamax)
Zolendronate IV	Pamidronate (Aredia)	Risedronate (Actonel)	Zoledronic acid (Zometa)

7. Are you aware of having an allergic (or adverse) reaction to any medication or substance?..... Yes No
   If yes, please list:_____
8. Have you been a patient in the hospital during the past 5 years?..... Yes No

9. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	Y/N	Ulcers	Y/N	Hepatitis A B C	Y/N
Chest Pain	Y/N	**Diabetes**	Y/N	Venereal Disease	Y/N
Congenital Heart Disease	Y/N	Thyroid Problems	Y/N	A.I.D.S	Y/N
Heart Murmur	Y/N	Glaucoma	Y/N	H.I.V. Positive	Y/N
Abnormal Blood Pressure	Y/N	Cold Sores/Fever Blisters	Y/N	Contact Lenses	Y/N
Mitral Valve Prolapse	Y/N	Emphysema	Y/N	Blood Transfusion	Y/N
Artificial Heart Valve	Y/N	Chronic Cough	Y/N	Hemophilia	Y/N
Heart Pacemaker	Y/N	Sickle Cell Disease	Y/N	Tuberculosis	Y/N
Rheumatic Fever	Y/N	Asthma	Y/N	Bruise Easily	Y/N
Arthritis/Rheumatism	Y/N	Hay Fever	Y/N	Liver Disease	Y/N
Cortisone Medicine	Y/N	**Latex Sensitivity**	Y/N	Yellow Jaundice	Y/N
Swollen Ankles	Y/N	Allergies or Hives	Y/N	Stroke	Y/N
Neurological Disorders	Y/N	Sinus Trouble	Y/N	Radiation Therapy	Y/N
Epilepsy or Seizures	Y/N	Fainting or Dizzy Spells	Y/N	Chemotherapy	Y/N
Artificial Joints (hips,knee,etc)	Y/N	Nervous/Anxious	Y/N	Tumors	Y/N
Psychiatric/Psychological Care	Y/N	Diet (Special/Restricted)	Y/N	Kidney Trouble	Y/N

10. Do you use more than two pillows to sleep?..... Yes No
11. Have you lost or gained more than 10 pounds in the past year?..... Yes No
12. Do you have or have you had any diseases, conditions, or problem not listed?..... Yes No
    If yes, please list:_____

Women: Are you pregnant or think you may be pregnant? Yes _____Months No **Nursing?** ..... Yes No
Women: Do you use birth control medications?..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature_____Date_____
History Review _____

_____

Dentist Signature_____Date_____

PERMISSION FOR RELEASE

Grand Haven Dental Care asks your permission to release to them the use of any and all photographs and /or testimonial information pertaining to your dental treatment at this office for the purposes of promotion of dental services offered by our office.

By signing below, you release us entirely and completely to use any photos and / or written information pertaining to your dental treatment, to be used in a professional manner to aid and educate patients and/ or other dental professionals. These materials may also be used in the promotion and advertising of dental techniques and procedures offered by this office to help others benefit from a health smile.

I understand the above statement and fully agree with what it says.

Patient Signature_____ Date_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anestetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18%APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature_____Date_____Witness_____

Parent/Responsible Party's Signature_____Relationship to Patient_____

HIPAA PRIVACY PRACTICES

I acknowledge that Grand Haven Dental Care "Notice of Privacy Practices" has been made available to me. I understand I have the right to Grand Haven Dental Care's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bill or in the performance of healthcare operations at Grand Haven Dental Care.

The Notice of Privacy Practice is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Grand Haven Dental Care's duties with respect to my protected health information.

Grand Haven Dental Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Sign_____ _____date

Print Name _____

By signing this form, I am acknowledging that I have been notified of the Privacy Practices

Please list below the names of person(s) authorized to gain access to patient account information:

_____

PRIVACY & COMMUNICATION

In general, the HIPPA privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the patient's office instead of their home. Occasionally our office will send out greeting cards, reminder postcards, call you regarding an appointment, etc. Written communication will be sent to the address specified on your patient intake unless you request otherwise.

I would like Appointment Reminders by:

Text-cell phone number_____

Email Communication _____

I give my permission to send occasional emails with birthday, gifts, news, specials and events.

(We will not sell or give your address to third parties)

WELCOME TO GRAND HAVEN DENTAL CARE!

Thank you for choosing our office to meet your dental health care needs. It is our optimal goal to provide you and your family with the highest quality of dental care, while maintain a friendly and relaxing environment. In order to keep our standard of care to a level which best serves your dental needs, we ask you to please observe the following guidelines.

Payment Options

To provide you with the best possible care we require you to pay for your treatment in full at the time of service. As a courtesy we will bill your dental insurance for you and give you a copy for your records. Please note, not all service may be covered by your insurance carrier and every insurance plan has its own limitations and exceptions.

In the space provided below, please indicate the method you plan to use to make your payments-Every time you come in.

CASH/CHECK/CREDIT & DEBIT CARDS **EXTENDED PAYMENT OPTIONS (REQUIRE APPROVAL)**

After **60** days of non-payment, a **$25.00** late fee will be added to your account to be compounded monthly.

Cancellation Policy

There are many times that our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give the office advanced notice of their need to cancel a scheduled appointment, this time can then in turn be allocated to those patients in urgent need of treatment.

Bearing these special needs in mind the office requires a minimum of two business days (Monday-Wednesday) if an appointment must be canceled. If less than two business day notices has been given to cancel an appointment, a **$104.00** fee may be assessed at accountant discretion. In the event that no notice is given or the patient does not show up for their scheduled appointment, which you may be charged up to ½ of the dollar amount of your appointment that was scheduled of $104.00 whichever is greater. Please note that this fee is not covered by dental insurance and payment is the patient's responsibility.

We at Grand Haven Dental Care welcome you and your family to our team of dental professionals and we look forward to taking care of your oral health needs.

_____ ____/____/_____

Authorized Signature Date

_____

Print Name

****FEES ARE SUBJECT TO CHANGE WITHOUT NOTICE****