GRIMES DENTAL
GROUP

Patient Information

Patient Name _____Date_____
Last First MI

(Preferred Name) _____ ☐ Male ☐ Female

☐Married ☐Single ☐Child ☐Other

Birth Date_____ Social Security #_____

Address (include apt #)_____
Street or **PO Box** City State Zip Code

Phone (Home)_____ (Cell)_____

Employer_____(Work)_____

Email Address_____

Spouse OR Responsible Party Information

Name_____☐ Married ☐ Single ☐ Other
Last First MI

Birth Date_____ Social Security #_____ ☐ Male ☐ Female

Phone (Home)_____ (Cell)_____

Emergency Contact Information

Name_____ Phone (Home/Cell)_____ (Work)_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient (Name)_____
☐ Google ☐ Facebook ☐ School/Work ☐ Other _____

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PRINT NAME: _____

Dental History

Have you ever had any complications following dental treatment? ( ) Yes ( ) No
If yes, please explain_____
(prolonged bleeding, numbness, etc)
Do your gums bleed while brushing? ( ) Yes ( ) No
Do you feel pain in any of your teeth? ( ) Yes ( ) No
Do you feel any clicking or pain in your jaw or difficulty opening or closing? ( ) Yes ( ) No
Date of last dental visit (estimate)? _____
Reason for visit today _____
Are you interested in straightening your teeth ( ) Yes ( ) No (We are INVISALIGN providers)
If you could change anything about your teeth, what would it be? _____

Health Information

Check (x) if you have or have had any of the followings:

( ) AIDS (HIV)
( ) Anemia
( ) Arthritis
( ) Artificial Joint/Joint Replacement
( ) Asthma
( ) Blood Disease
( ) BLOOD THINNER
( ) Cancer
( ) Diabetes (Last A1C: _____)
( ) Dizziness
( ) Eating Disorders
( ) Epilepsy
( ) Excessive Bleeding
( ) Fainting
( ) Glaucoma
( ) Head Injuries
( ) HEART DISEASE
( ) HEART MURMUR
( ) HEPATITIS (circle: A, B, or C)
( ) HIGH BLOOD PRESSURE
( ) KIDNEY DISEASE
( ) LATEX ALLERGY
( ) LIVER DISEASE
( ) Mental Disorders
( ) Nervous Disorders
( ) PACEMAKER
( ) PREGNANCY (CURRENT) due date _____
( ) Radiation Therapy
( ) Respiratory Problems
( ) RHEUMATIC FEVER
( ) Sinus Problems/Hay Fever
( ) Stomach Problems
( ) STROKE
( ) Tuberculosis
( ) Tumors
( ) Ulcers
( ) Thyroid Disease
( ) CODEINE ALLERGY
( ) PENICILLIN ALLERGY
( ) SULFA ALLERGY
( ) PREMED/ANTIBIOTIC NEEDED
( ) Tobacco Use

***Office Use* Provider Initials: _____**

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Are you currently taking or have taken in the past any of the following Bisphosphonates for Osteoporosis treatment?

( )Actonel ( )Fosamax ( )Boniva ( )Didronel ( )Aredia ( )Skelid
( )Reclast ( )Zometa ( )Fosamax Plus D ( ) Prolia ( ) Other: _____

List ALL MEDICATIONS and their use (including aspirin, birth control, etc):

List ALL SUPPLEMENTS as these can affect the oral cavity:

List ALL ALLERGIES not addressed on page 1:

Recent SURGERIES (within last 5 years) and approximate DATE:
**Does not include dental work unless it was a major surgery

Primary Doctor's Name: _____Phone: _____

Facility: Unity Point in _____ Mercy in _____ Other _____

To the best of my knowledge, all the above information is true and correct. If I have any change in my health, I will inform the doctor at the next appointment without fail.

_____ _____
(Signature of Patient, Parent, or Legal Guardian) (Date)

***Office Use* Provider Initials: _____**

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Financial Options/Policy

PLEASE NOTE THAT COINSURANCE/DEDUCTIBLE IS DUE **AT TIME OF SERVICE IF APPLICABLE.
THIS MEANS PAYMENT IS DUE AT THE TIME OF YOUR APPOINTMENT**

1. I HAVE NO Dental Insurance: I understand I am responsible to pay with check/credit card on all visits as treatment is completed. I understand if I am paying in cash, the full amount is due BEFORE treatment can begin. I also choose the following option(s) if needed:

( ) I wish to apply for your in-office finance plan (Care Credit). I understand on approved credit; I may finance up to $10,000 and make monthly payments over 6 months, interest free.
( ) On treatment amounts over $500, I elect to pay half (cash/check/card apply) on the preparation date and the remaining balance on the completion date for multiple appointment treatment plans.

2. I HAVE dental insurance: I understand I am responsible to pay my deductible and any uninsured portions (coinsurance) as treatment is completed before leaving the office, but I also choose the following option(s) if needed:

( ) On treatment amounts over $500, I elect to utilize a payment plan up to four months. I understand payment 1 is due at time of service and the remaining 3 payments will be automatically deducted each month thereafter.
( ) On treatment amounts over $500, I elect to pay the uninsured portion on the office finance plan (Care Credit). I understand on approved credit I may finance up to $10,000 and make monthly payments over an extended length of time or choose an interest free option as offered by Care Credit.

I understand the dental specialists at Grimes Dental Group will provide dental services to myself and my dependents using the benefits of my insurance coverage to the full extent; however, insurance benefits do not determine the treatment needed, recommended or completed. The dental expertise of the doctor will determine the best treatment for each patient's dental health regardless of insurance coverage. As a courtesy, an insurance estimate will be supplied with the insurance information available. These estimates are only estimates and do not guarantee payment to be received by insurance. Any amount not paid by the insurance will be the responsibility of the patient or patient's responsible party at time of service.

As a condition of your treatment by this office, **financial arrangements must be made in advance**. If you must have a statement mailed, we will keep a card on file in the event the bill does not get paid. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before major treatment. I hereby authorize the treating dentist of Grimes Dental Group to release to the insurance company any information including the diagnosis and records of any treatment rendered to me during the period of such dental care. I also authorize and request the insurance company to pay directly to the above clinic the amount due for dental treatment. I also authorize the release of my dental records to referring dental providers or other only as deemed necessary by the dentist at Grimes Dental Group.

I have read the above conditions and agree to their content:

_____ Date_____

(Signature of Patient, Parent, or Guardian)

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HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

PLEAE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your 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 our treatment, payment activities, healthcare, 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 is available on our website.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain. A copy can be obtained upon request.

Right to Revoke: You will have the right to revoke this consent at any time. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature: I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Please list any persons you wish to have access to your account: (All areas of account will be accessible, unless documented below. Ex: Spouse, Parent, Child)

1._____2._____
3._____4._____

Patient Signature _____ Date _____
(parent or legal guardian if necessary)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other, please specify: _____

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Missed Appointments/Cancellations

At Grimes Dental Group, we put our faith in you to keep your appointment. When we set up an appointment, a specific amount of time is reserved especially for you. Many offices double or even triple book appointments to prevent from being financially damaged as a result of a missed appointment. However, double booking appointments does not allow us to give the care and attention needed to provide the best quality dentistry and for this reason we choose not to do it. If for any reason you must cancel or change your appointment, it is important that you give our office at least a **48 business hour notice** to offer that spot to someone else. We understand that true emergencies happen. If this is the case, we will absolutely work with you.

**Short-notice cancellation = Less than 48 business hour notice of cancellation
**A "no-call, no show" is a short-notice cancellation/missed appointment.

- **1st missed appointment:** If an appointment is missed or cancelled less than 48 hours in advance, we will re-iterate our policy and find another appointment time that you know you can make work.
- **2nd missed appointment:** If an appointment is missed or cancelled less than 48 hours in advance a second time, there will be a **$50** fee charged to your account for the missed time. You will be placed on a short notice list and will be notified when there is a cancellation or opening in the schedule. No appointments can be scheduled ahead of time and the patient's account will need to be placed back in good standing before any work can be done. The decision to place the patient's account back in good standing lies at the sole discretion of the dentist.

For ALL appointments after 3rd missed appointment: We reserve the right to dismiss you as a patient at this time if we feel necessary.

Late arrival: When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive more than 15 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment.

I have read the policy above. I understand and agree to abide by the listed terms.

Patient Signature _____ Date _____
(parent or legal guardian if necessary)