GROSCH DENTAL

Today's date: _____ **ABOUT YOU (PLEASE PRINT)**

WHOM MAY WE THANK FOR REFFERING YOU? _____

NAME: _____ ☐ FEMALE ☐ MALE

ADDRESS: _____ CITY _____ STATE _____ ZIPCODE _____

DAYTIME PHONE #: _____ CELL PHONE# _____ BUS. PHONE _____

BIRTH DATE: ____/____/____ MARITAL STATUS: S/M/W/D

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you. Thank you

DRIVERS LICENSE # _____

SSN#: _____ EMAIL ADDRESS: _____

Place of employment _____

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____

Address: _____ City _____ State _____

Phone#: _____ Cell# _____

INSURANCE INFORMATION

Insurance Company Name: _____

Employer: _____ ID# _____ Group# _____

If your spouse is Policyholder

Spouse Name: _____ Date of Birth ____/____/____ Spouse SSN# _____

Spouse Employer: _____ Spouse Phone#: _____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim; I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Grosch Dental, LLC. **Initials** _____

PLEASE READ VERY IMPORTANT - APPOINTMENT RESCHEDULE POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advance notice of two business days**. We understand that conflicts arise: however failing your appointment or canceling without adequate notice more than twice will result in a $25.00 charge. The time we schedule for your dental needs are exclusively reserved for only you. **Initials** _____

HEALTH HISTORY

Are you under the care of a physician? Y N Physician Name: _____ **Phone# (** ___ **)** _____

Address: _____ **City:** _____ **State** _____ **Zip** _____

Have there been any changes in your health within the last year? *Y N* If Yes explain: _____

_____

Date of Last Physical Exam: _____ **Have you had a serious illness or surgery in the last 5 years? Y N** _____

If yes explain: _____

Has a Physician or previous Dentist recommended that you take antibiotics prior to your dental appointments: Y/ N If yes, who was the prescribing Doctor? _____ **Phone #** _____

What medication was prescribed? _____ _____ _____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Y/N Date: _____

Are you presently taking any medications? Y/N If yes please list all medications box provided below.

Medication	Condition

Please check all that apply towards your health:

☐ AIDS/HIV Positive	☐ Drug Addiction	☐ Hepatitis B or C	☐ Rheumatism
☐ Alzheimer's Disease	☐ Easily Winded	☐ Herpes	☐ Scarlet Fever
☐ Anaphylaxis	☐ Emphysema	☐ High Blood Pressure	☐ Shingles
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Stroke
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Swelling of Limbs
☐ Breathing Problem	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Bruise Easily	☐ Genital Herpes	☐ Lung Disease	☐ Tonsillitis
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chemotherapy	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Chest Pains	☐ Heart Attack/Failure	☐ Parathyroid Disease	☐ Ulcers
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Psychiatric Care	☐ Venereal Disease
☐ Congenital Heart Disorder	☐ Heart Pace Maker	☐ Radiation Treatments	☐ Yellow Jaundice
☐ Convulsions	☐ Heart Trouble/Disease	☐ Recent Weight Loss	
☐ Cortisone Medicine	☐ Hemophilia	☐ Renal Dialysis	☐ **NONE OF THE ABOVE**
☐ Diabetes	☐ Hepatitis A	☐ Rheumatic Fever	

(For women) Are you currently pregnant? ☐ **Yes** ☐ **No** If yes, how many months? ☐

Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ **Yes** ☐ **No**

Are you aware that antibiotics can decrease the effectiveness of birth control? ☐ **Yes** ☐ **No**

Please check if you're allergic to any of the following:

☐ *Local anesthetics* ☐ *Sulfa drugs* ☐ *Codeine/other narcotics* ☐ *Penicillin/other antibiotics* ☐ *Aspirin* ☐ **NONE**

☐ *Latex sensitivity* ☐ *Barbiturates, sedatives, sleeping pills* ☐ *Shellfish, iodine or red wine* ☐ *Other* _____

DENTAL HISTORY

How do you feel about your smile and the look of your teeth? _____

Date of your last hygiene visit? ___/___/___ **What is the main reason for your visit today and in the future?**

☐ Tooth pain ☐ I need a check-up ☐ Cleaning ☐ Implants

☐ Whitening ☐ Cosmetic dentistry ☐ Other _____

NOTE: BOTH DOCTOR AND PATIENT ARE ENCOURAGED TO DISCUSS ANY AND ALL REVELANT PATIENT HEALTH ISSUES PRIOR TO TREATMENT. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

1st Year Update- Patient Signature - _____ Date: _____ Dr/Hyg Initials ____

2nd Year Update-Patient Signature - _____ Date: _____ Dr/Hyg Initials ____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES
PATIENT CONSENT FORM

Grosch Dental, LLC * 2408 Hwy 94 South Outer Road * St. Charles, MO 63303
(636) 928-4888 * GroschDental.com* groschdentalllc@gmail.com

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability or 1996 (HIPAA). I understand that this information can and will be used to:

- ◎ Provide and coordinate my treatment among a number of health/dental care providers who may be involved in that treatment directly and indirectly.
- ◎ Obtain payment from third-party payers for my health care/dental services.
- ◎ Conduct normal health care operations such a quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

AUTHORIZATION TO RELEASE INFORMATION TO OTHERS

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental condition and/or treatment disclosed to someone else indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

☐ You May Disclose My Information To The Following ☐ Do Not Disclose My Information to Anyone But Me

1. _____ Relationship to Patient _____ Date _____
2. _____ Relationship to Patient _____ Date _____

FOR OFFICE USE ONLY: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:
☐ The patient refused to sign ☐ Communication Barriers ☐ Emergency Situation ☐ Other