PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Gender: ☐ Male ☐ Female ☐ Unknown Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency Phone

Relationship

receive texts Y N

Referral source

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Grand Avenue Dental Care

Eaglesoft Medical History Update 1/12/17

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes	No	If yes
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Have you ever had a serious head or neck injury?	Yes	No	If yes
Are you taking any medications, pills, or drugs?	Yes	No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Yellow Jaundice	Yes	No	Anxiety/Depression	Yes	No						

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:

GRAND AVENUE DENTAL CARE

Acknowledge of Receipt of Notice of Privacy Practices

You may refuse to sign This Acknowledgment

I, _____ have received a copy of this office's Notice of Privacy Practice

_____

(Please Print Name)

_____

(Signature)

_____

(Date)

I, _____ give permission to GADC to release my Personal information to the following person(s):

_____ _____ _____

(Name) (Number)

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

_____

_____

_____

Staff Signature: _____

Date: _____

GRAND AVENUE DENTAL CARE

FINANCIAL POLICY

GADC is committed to providing you with the highest quality dental care, using only the best material and technology available in the market today, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment. Your clear understanding of the Financial Policy and your treatment plan is important to our professional relationship. We encourage you to ask questions and to be involved in treatment decisions.

FINANCIAL AGREEMENT:

Patients are expected to pay for our services at the time they are rendered. Payment options: pay with cash or check to receive a 5% courtesy, Credit Card (3% usage fee will apply) – we accept Visa, MasterCard, American Express or Discover, Debit Card or apply for one of our in-office options available upon approval; Care Credit, Sunbit or Simplify. We mail monthly statements to all patients with an outstanding balance, with interest charges of 1.25% when balance exceeds 90 days.

Insurance Information:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. In order to do this, please verify your insurance each time you check in for an appointment. Based on the information your insurance company provides, we will do our best to explain how your insurance works in our office, estimate patient financial responsibility and maximize your benefits.
All charges you incur are your responsibility regardless of your insurance coverage.

APPOINTMENTS:

In order to serve you better, we try to maintain an efficient appointment system. Please give 24 hour notice when cancelling appointments. After 3 missed appointments you may be put on a "same day only" alert. We strive to consider all our patients needs when scheduling appointments.
Minor Patients must be accompanied by an adult at all times unless there have been prior arrangements!

I understand and accept the GADC financial agreement and have had any and all questions answered to my satisfaction.
I understand and agree Payment is expected at the time of service. Either pay in full with cash or check to receive 5% courtesy, pay estimated OOP in full or agreed upon payment arrangement. Addition fees may be added to accounts 90 days past due.
This form must be signed in order to proceed with your scheduled appointment.

A photocopy of agreement is considered as valid as the original.

_____
Parent or Responsible Party Name (Please Print)

_____
Child Name (Please Print)

_____ _____
Patient Responsible Party Name (signature) Date

_____ _____
Staff Initials Date