GREENLEE
DENTAL

DEMOGRAPHICS:

Name:

What name does the patient prefer to go by?:

Gender: **SSN:** **Phone Number:**

Birth Date: **Email Address:** **Number type Type:**

Address:

City: **State:**

OK

Who is filling out the form today?

If someone other than the patient please complete the following.

Name: **Phone Number:**

Who has legal custody of the patient?

Primary Contact Details - who should we contact for scheduling? *ONLY COMPLETE IF NOT THE PATIENT*

Primary Contact Name:

Address:

Relationship to Patient: **City:** **State:**

Postal Code:

Phone Number:

How did you hear about us

RESPONSIBLE PARTY / GUARANTOR INFORMATION

Is the patient also the guarantor?

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If not please complete the following:

Guarantor's Name: **Address Line 1:**

Guarantor's DOB: **City:**

Relationship to Patient: **State:**

Phone Number: **Postal Code:**

Please list 2 contact names to whom practice can release PHI information (HIPAA)

Name: **Name:**

Phone Number: **Phone Number:**

EMERGENCY CONTACT

Name: **Relationship:** **Phone Number:**

INSURANCE INFO:

Subscriber's Name:

Insurance Carrier:

Subscriber's Social/Member ID:

Insurance Phone number:

Subscriber's Employer:

Group Number:

Signature **Date:**

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Dental History

Previous Provider:

Do you or your child have any of the following, check all that apply :

- ☐ **Cavities/Decay**
- ☐ **Lip Sucking/Biting**
- ☐ **Speech Problems**
- ☐ **Nail Biting**
- ☐ **Pacifier / Thumb / Finger Sucking**
- ☐ **Mouth Breathing**
- ☐ **Tongue Thrust**
- ☐ **Jaw Problems**
- ☐ **Grinding Teeth**
- ☐ **History of orthodontic treatment (Braces)**
- ☐ **History of pain/tenderness in their jaw joint**
- ☐ **TMJ/TM**

Is this your child's first dentist visit? Y / N N/A
Nursing/Bottle Habits:

Reason for visit:

Date of last dental visit:
Date of last dental X-rays:

How often do you floss?:
How often do you brush?:

- ☐ **Bad Breath:**
- ☐ **Bleeding, Red, Swollen Gums**
- ☐ **Broken/Loose teeth or fillings**
- ☐ **Clicking or popping jaw**
- ☐ **Grinding teeth**
- ☐ **Pain around ear/side of face**
- ☐ **Sores/Blisters in mouth**

List any other dental concerns/pain:

What did you like the <u>most</u> about your previous dental office?:
What did you like the <u>least</u> about your previous dental office?:

Are you interested in whitening your smile?
Are you happy with your smile? If not, what would you change?

Signature **Date:**

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Medical History

Allergies:

- ☐ Aspirin
- ☐ Allergy
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa

List any other allergies:

CHECK ALL THAT APPLY:

- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ AIDS/HIV
- ☐ Anemia / Bleeding Problems
- ☐ Artificial Heart Valves
- ☐ Blood Disease
- ☐ Congenital Heart Lesions
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ Arthritis / Rheumatism / Gout?
- ☐ Artificial Joints / Bones?
- ☐ Asthma?
- ☐ Cancer?
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Radiation Treatment (Xray/Cobalt)?
- ☐ Shortness of Breath (Breathing Problems)
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Problems?
- ☐ Tuberculosis
- ☐ Tumor / growth on head / neck
- ☐ Ulcer
- ☐ EpilepsyFainting / Dizziness
- ☐ Headaches (Frequent)NO
- ☐ HepatitisYES
- ☐ HerpesYES
- ☐ Kidney Disease?
- ☐ Liver Disease?
- ☐ Nervous Problems
- ☐ Pregnant
- ☐ Nursing

Psychiatric CareList any other medical issues you have:

_____

_____

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List any serious Illnesses / surgeries / hospitalizations:

Please list medications you are taking:

Do you Smoke? Y / N / Sometimes

Do you drink Alcohol? Y / N / Sometimes

High Sugar intake? Y / N / Sometimes

Is the patient under the care of a physician? Y / N Physician Name:

Is the patient physically, mentally or emotionally impaired

Describe the patient's current physical health: poor - fair - good - exceptional

Signature **Date:**

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Dental Practice Financial Policy

The practice depends upon reimbursement from patients for the costs incurred in their care.
Financial responsibility on the part of each patient must be determined before treatment.
As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in full at the time services are rendered.

All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.
Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.
Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

Cancellation Policy

We do understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 48 hr notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting. We appreciate your understanding and consideration regarding our cancellation and failed appointment policy. A $50 fee will be applied for no shows, or cancellation after 48 hr notice. If multiple cancellations occur we will be unable to reserve future time, and will be scheduled within 24 hrs of service date.

Notice: X-rays and Insurance Coverage

We will recommend that certain x-rays be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.

Signature **Date:**