PATIENT REGISTRATION

First Name:_____ Middle Initial:_____Last Name:_____

Address:_____ City, State, Zip:_____

Home Phone (__)_____ Work Phone: (__)_____ Cell Phone: (_)_____

Birth Date:_____Age:____ Sex: Male or Female

Social Security Number:_____ Occupation:_____

Employer:_____ Email Address:_____

Marital Status: Married Single Divorced Separated Widowed

Spouse Name:_____

Referring Dentist:_____

Physician Name:_____

Have you ever been a patient here before?_____

Do you premedicate before dental procedure with antibitoics?_____ If so, please explain why:_____

Responsible party if no dental insurance:_____

If minor patient's names:_____

Primary Dental Insurance Information

Name of Insured:_____

Relationship to Patient: Self Spouse Child Parent Step Parent

Insured Social Security Number:_____Insured Birth Date:_____

Employer:_____ Dental Insurance Name:_____

Secondary Dental Insurance Information:

Name of Insured:_____

Relationship to Patient: Self Spouse Child Parent Step Parent

Insured Social Security Number:_____Insured Birth Date:_____

Employer:_____

Dental insurance Name:_____

MEDICAL HISTORY

Patient name:

Height_____ Weight_____ Date of last physical exam:

1. Do you have injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, explain.

2. Has there been any changes in your general health within the past year? If yes, explain.

3. Are you under the care of a physician for a current problem? If yes, explain.

4. Have you ever been hospitalized within the past 5 years? Please specify.

5. Have you received therapy for alcoholism or drug addiction during the past 5 years?

6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/medications?

7. Is there any condition concerning your health that the doctor should be told?

8. Do you wish to speak with the doctor privately about anything?

9. Have you had abnormal bleeding with previous extractions, surgery, or trauma?

10. Have you ever required a blood transfusion?

11. Have you ever had radiation for any condition?

12. Have you ever tested positive for HIV infection or AIDS? Is so state date diagnosed and treating Dr.

13. Are you required to take antibiotics prior to dental treatment?

14. Do you have, or have you had any of the following? Please circle all that apply.

High blood pressure	Diabetes
Heart murmur or prolapsed valve	Thyroid problems
Joint prosthesis (hip, knee, etc.)	Sinus trouble
Rheumatic fever or rheumatic heart disease	Stomach ulcers, colitis
Congenital heart disease	Hepatitis, jaundice, liver disease
Cardiovascular disease: heart attack, stroke bypass	Kidney problems
Prosthetic heart valve	Psychiatric treatment
Blood disorder (e.g., anemia)	Fainting spells or seizures
Venereal disease	Epilepsy
Asthma	Cancer
Allergic to latex	Temporomandibular joint problems (TMJ)
Low blood pressure	Low blood sugar
Chest pain, angina	Dialysis
Swollen ankles, arthritis or joint disease	Irregular heart beat
Cardiac pacemaker	Contagious diseases
Heart surgery	Bronchitis, chronic cough
Delay in healing	Hay fever or sinus problems
Tuberculosis	Problems with the immune system
Emphysema	Difficult breathing or other lung trouble
X-Ray treatment or chemotherapy	Chronic fatigue or night sweats
On a diet	History of drug abuse
History of alcohol abuse	Wear contact lenses
Eye disease or glaucoma	Bruise easily
Infectious mononucleosis	Gallbladder trouble

15. Are you taking any herbal medicine (i.e., St. Johns Wort)?

16. Have you ever taken the “fen-phen” diet?

17. Do you have any disease, condition or problem not listed above? Specify.

18. Are you taking bisphosphonates now or have you ever taken them in the past (Fosamax)?

19. Are you taking any medication or drugs? If yes, please list them below.

Medication start date	Quantity	Medication prescribed	Reason for taking this medication	Completion date

Women only:

Possibility of pregnancy:_____ Nursing:_____

Estimated delivery date:_____ Taking birth control pills: Yes or No

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Injury:

This visit is related to an accident: Yes or No Work related: Yes or No

Date of Injury:
Insurance Company Handling the claim:
Claim number:

Name of Attorney/Adjustor:

Attorney/Adjustor Telephone #:

Physicians Information:	
Physician Name:	Physician Phone #:
Specialist Name:	Specialist Phone #:

Emergency Contact Information:
First name
Last name
Home phone #
Work phone #
Cell phone #

20. Have you been out of the country recently? Is so, where and for how long?

Grandville Endodontics

Your Privacy is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

(Adults and Minors)

I have received a copy of the Notice of Privacy Practices of Grandville Endodontics. I hereby authorize, as indicated by my signature below, Grandville Endodontics to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Minor's first/last name Parent/guardian first/last name or legal guardian

_____ _____

Print patients first/last name Address

_____ _____

Signature Date

Please check your preferred means of communication:

- You may contact me at my home telephone number _____
- You may contact me on my mobile telephone number _____
- You may contact me on my work telephone number _____
- You may send me an email at: _____
- Other form of contact information: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added/Removed:_____
2. _____Date Added/Removed:_____
3. _____Date Added/Removed:_____

FOR OFFICE USE ONLY

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

Individual refused to sign

- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgment
- Other (Please Specify) _____

Staff Person Initials _____

Patient Consent Form

Clinical:

- I authorize Grandville Endodontics, PC to perform all recommended treatment by Dr. Licari.
- I authorize Grandville Endodontics, PC to take radiographs, CBCT scans, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material" as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.
- I authorize the use of anesthetics, sedatives and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissue, pain, itching, vomiting, paresthesia, numbness, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial:

- I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 2% MPR or 24% APR automatically may be tabulated into my account if my balance exceeds 90 days. Should my account become delinquent, I understand that I am 100% responsible for all additional collection costs, attorney fees and or court costs.

Insurance:

- I authorize the practice to release to staff, hospitals health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other records, and other diagnostic materials about my medical history, services rendered, or recommended treatment.
- I authorize the practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "my signature on file" and assign to the practice the insurance benefits providing assignment is accepted.
- I understand that not all dental insurance companies cover services that Grandville Endodontics may recommend and or perform and that if there is a balance it is my responsibility to pay that balance. I am 100% responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to ALL terms and conditions herein.

Patient's Name:_____ Date:_____

Patient's signature:_____

IF PATIENT IS A MINOR PARENT/GUARDIAN SIGN BELOW

Patient's Name:_____ Date:_____

Parent/Guardian signature:_____ Date:_____