JENNIFER GRANT FAMILY DENTISTRY
WELCOME

Thank you for choosing our practice for your dental needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help!

Today's Date:	PLEASE PRINT

PATIENT INFORMATION

Patient's Last Name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this patient a minor? ❑ Yes ❑ No	If minor, what is the parents name?	Patient Social Security Number:	Patient Birth Date: / /	Age:	Sex: ❑ M ❑ F

If student, School _____ Year/Grade _____	**Driver License #:**

Street Address:	City:	ZIP Code:

Home Phone Number: ( )	Cell Phone Number: ( )	Appointment confirmation preference: ❑ Home ❑ Work ❑ Cell ❑ Text ❑ Email

Occupation:	Employer: Employer Phone Number: ( )	Email Address:

Whom may we thank for referring you to us? ❑ Dr. _____ ❑ Insurance Plan ❑ Internet

❑ Family _____ ❑ Friend_____

Is anyone in your household a patient of Dr. Grant's? If yes, who?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No Social Security Number:

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Dental Insurance Company:

Subscriber's name:	Subscriber's S.S. Number:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Jennifer Grant, D.D.S. I understand that I am financially responsible for any balance. I also authorize Jennifer Grant Family Dentistry or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

JENNIFER GRANT FAMILY DENTISTRY
DENTAL & MEDICAL HEALTH HISTORY

Patient Last Name:	Patient First Name:

DENTAL HISTORY	
Date of last dental visit:	Former dentist:
Date of last dental x-rays:	Have you had trouble from previous dental care:
Have you had periodontal treatment:	If yes, please explain what happened:

MEDICAL HISTORY		
Physician's name:	Name or address of clinic:	
Physician's phone #:	Which pharmacy do you use?	
Have you had any serious illnesses or operations?		If yes, describe:
Please provide approximate dates:		
Have you had abnormal bleeding associated with previous extractions or surgery?		
Have you had previous skin reactions to jewelry or know of any allergy to metal?		
Are you currently taking any medications?		If yes, please list them:
Women, are you pregnant?	If yes, due date:	Nursing: Using birth control pills?

PLEASE CHECK IF YOU HAVE/HAD							
AIDS or HIV +		Circulatory Problems		Osteoporosis		Scarlet Fever	
Anemia		Cold Sores/Fever Blisters		Jaw Pain/Clicking		Shortness of Breath	
Arthritis		Congenital Heart Lesions		Kidney Disease		Sickle Cell Disease	
Artificial Heart Valves		Diabetes		Liver Disease		Sinus Trouble	
Artificial Joints		Emphysema		Mitral Valve Prolapse		Sleeping Problems	
Asthma		Epilepsy		Nervous Problems		Snoring Problems	
Back Problems		Fainting		Pacemaker		Steroid Treatment	
Blood Disease		Glaucoma		Persistent Cough		Stroke	
Blood Transfusion		Headaches		Psychiatric Care		Swelling of Feet/Ankles	
Bruise Easily		Heart Murmur		Radiation to head/neck		Thyroid Problems	
Cancer		Hemophilia		Reaction to Medication		Tobacco Habit	
Chemical Dependency		Hepatitis		Respiratory disease		Tonsillitis	
Chemotherapy		High Blood Pressure		Rheumatic fever		Tuberculosis	
Do you have a disease, condition, or problem not listed that you think I should know?						Ulcers	
						Venereal Disease	

ALLERGIC REACTIONS
Are you allergic or have you ever had an adverse reaction to any drugs or medicines? ____ YES ____ NO
If yes, please explain:

AUTHORIZATION
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party and/or health practitioners.
_____ Signature of Patient (or parent if patient is a minor)
_____ Date

JENNIFER GRANT FAMILY DENTISTRY
CONSENT AND AGREEMENT FOR TREATMENT

Please read the following information carefully. After you have read this Consent and Agreement, please initial where indicated and print and sign your name below to accept the terms of this agreement.

1. **Consent to Treat:** As a consenting adult, I agree to permit the dental staff at Dr. Jennifer Grant's office to provide dental care to myself, my child, or patient representative as applicable.

   Initials: _____

2. **Drugs and Medications:** I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

   Initials: _____

3. **Follow-Up Appointments:** I understand that by accepting treatment at the dental office of Jennifer Grant, D.D.S., I also consent to future follow-up appointments for the purpose of assessing the outcome of dental treatment provided to me as the patient.

   Initials: _____

4. **Changes in Treatment Plan:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examinations, the most common being root canal therapy routine restorative procedures. I give my permission to Dr. Grant to make any/all changes.

   Initials: _____

5. **No-show/Cancellation Policy:** Our goal is to provide high quality care at low cost to our patients and in fairness to other patients and the doctor, we require at least 24 hours' notice when canceling an appointment. **You may be charged $25 for every 30 minutes that is scheduled for missed appointments without 24 hours' notification, which will be due and payable from you.** The practice reserves the right to dismiss patients with excessive cancelled appointments.

   Initials: _____

6. **Right to Discontinue Treatment:** Our office has the right to discontinue treatment for any appropriate reason, such as, excessive cancellations. In such cases, the patient or patient's representative agrees to accept full responsibility for pursuing alternate professional dental care. A letter will be sent informing the patient or patient's representative that treatment is being discontinued. All records pertaining to the treatment and diagnosis of patients are the property of Jennifer Grant, D.D.S. Records and x-rays will be duplicated upon written request.

   Initials: _____

7. **Notice of Privacy Policies:** Dr. Grant may release information to other entities or health care providers for treatment, payment of services, and for health care operations as described in the "Notice of Privacy Policies". We have prepared this detailed document to help you better understand our policies in regard to the use and disclosure of your personal health information. I have been given the opportunity to review and receive a copy of the Notice of Privacy Practices.

   Initials: _____ Printed Name:_____ Date:_____

JENNIFER GRANT FAMILY DENTISTRY
OFFICE FINANCIAL POLICY

If you have dental insurance, it is important to understand your policy so you can receive the maximum benefits you are entitled to. To save time and confusion, and for us to better serve you, we strongly recommend that you get an explanation of benefits on your policy from either your employer or the insurance company itself. Please keep in mind that the policy you carry is a contract between you and the insurance company. As a courtesy to our patients, we will bill your insurance for all services done in our office. However, please be aware that most insurance plans only cover a portion of dental fees and that you may be responsible for payment of any of the following:

- Annual deductible: This is an amount of money that must be paid before treatment begins
- Fees above your policy maximum: This is the amount you are allowed in a specified amount of time.
- Exclusions and Waiting Periods: Most insurance plans have some treatments that are not covered at all or there is a waiting period in place before the insurance company would pay for the service.

If you can provide accurate insurance information to our office, and with verification of your coverage, we will ***estimate*** the cost of your treatment at the time services are rendered. You will be responsible for your ***estimated*** portion the day that treatment is provided. ***The amount we estimate is <u>not a guarantee</u> of what your insurance will pay. You could owe more than your original payment or you could be refunded money if your insurance plan pays more than expected.***

It is possible that you still may have to pay a patient portion. This all depends on the level of benefits you have purchased from the insurance company. If you cannot provide accurate insurance information by your first visit, we will ask you to pay in full for services that are provided that day. Until we have received the information needed to bill your insurance, it will become your responsibility to collect any monies from them. We will provide a statement for you that will describe the services that occurred that day.

You will receive a monthly statement from us whenever there is a balance on your account. If your insurance company has not paid your claim(s) within 45 days, it is your responsibility to find out why. **You are responsible for any balances on the account not paid by insurance. After 90 days accounts are considered overdue regardless of insurance company delays. Overdue accounts will be subject to a monthly late fee or turned over to a collection agency with a fifty percent fee added to the account balance.**

Please feel free to call our office if you have any questions or concerns regarding your monthly statement.

If you do not have insurance coverage, payment in full will be due the day services are rendered. We accept many forms of payment including: cash, checks, Visa, MasterCard, Discover, American Express and the Care Credit Program. If you are interested in learning more about the Care Credit program, please ask our front office staff.

By signing below, I am indicating that I have read and understand the terms of the Consent and Agreement for Treatment and Office Financial Policy. I am either the patient or have the authority to give consent for the patient. I give consent to Dr. Jennifer Grant to perform necessary or appropriate tasks for proper dental and physical examination, diagnosis, and treatment, including local anesthesia.

_____ _____

Patient or Patient Representative Signature Date

_____ _____

If Patient Representative, Relationship to Patient Witness