# WELCOME

**Gordon Green, DDS • Brooks Green, DDS • Nichole Barnett, DDS**
Cosmetic & Comprehensive Dentistry
*"Changing Faces, Changing Lives."*
**questions@drgreendental.com**

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*We Welcome New Patients*

## 1 About You

**Today's Date:**_____

**Name:**_____

❑ Male ❑ Female

Birth date: ___/___/___ Age:_____SS#:_____

Home Address:_____

Email:_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone #:_____Cell Phone #:_____

Work Phone #:_____

Employer:_____

How long there?_____ Occupation:_____

**Whom may we thank for referring you?**_____

Other family members seen by us: _____

## 2 Dental Insurance

**Primary Dental Insurance**

**Insurance Co. Name:** _____

**Insurance Co. Address:** _____

**Insurance Co. Phone #:** _____

**Group # (Plan, Local or Policy #):** _____

Insured Name:_____ Relation:_____

Insured's Birthday:___/___/___ Insured's SS#:_____

Insured's Employer:_____

**Secondary Dental Insurance**

**Insurance Co. Name:** _____

**Insurance Co. Address:** _____

**Insurance Co. Phone #:** _____

**Group # (Plan, Local or Policy #):** _____

Insured Name:_____ Relation:_____

Insured's Birthday:___/___/___ Insured's SS#:_____

Insured's Employer:_____

## 3 Spouse / Parent Information

His/Her Name:_____

Employer:_____

Work Ph #:_____Ext:_____

Birth date:___/___/___

**Person Responsible for Account:**

Work Ph #:_____Ext:____Home Ph #:_____

Billing Address:_____

Relationship:_____SS#:_____

Employer:_____

## 4 Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: _____Last Visit Date:_____

Date last physical exam:_____

**Required: List Emergency Contact**

Their Name:_____

Relation:_____

Work Ph #:_____Home Ph #:_____

# 5 Medical History

**Are you currently under the care of a physician?** ❑ Yes ❑ No

Please explain:_____

Are you taking any prescription / over-the-counter drugs?

❑ Yes ❑ No

Please list each one or attach complete list:_____

_____

**For Women:** Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week#_____

Are you nursing? ❑ Yes ❑ No

Do you anticipate becoming pregnant? ❑ Yes ❑ No

**Have you had any of the following diseases or medical problems? (Please Circle Y for Yes or N for No)**

| | |
|---|---|
| Y N Heart Attack | Y N Depression / Mental Health |
| Y N Stroke | Y N Epilepsy / Seizures / Fainting |
| Y N Cancer | Y N Diabetes |
| Y N Chemotherapy | Y N Tuberculosis (TB) |
| Y N Radiation Treatment | Y N Drug Abuse |
| Y N Heart Murmur | Y N Alcohol Abuse |
| Y N Heart Surgery / Pacemaker | Y N Hemophilia / Abnormal Bleeding |
| Y N Mitral Valve Prolapse | Y N Ulcers |
| Y N Rheumatic Fever | Y N Colitis |
| Y N HIV+ / AIDS | Y N Congenital Heart Defect |
| Y N Shingles | Y N Anemia |
| Y N Kidney Problems | Y N Arthritis |
| Y N Artificial Bones / Joints | Y N Asthma |
| Y N Artificial Valves | Y N Emphysema |
| Y N Difficulty Breathing | Y N Hepatitis |
| Y N Sinus Problems | Y N Blood Transfusion |
| Y N High Blood Pressure | Y N Severe / Frequent Headaches |
| Y N Low Blood Pressure | Y N Have you had a sleep study |
| Y N Do you snore | Y N Do you use a C Pap machine |

**Please list any medical condition that we should be aware of:**

_____

_____

Do you have any artificial joint replacements? _____

Do you need to take antibiotics prior to treatment?_____

**Do you take any oral or IV bisphosphontate drugs?**_____

**Are you allergic to any of the following drugs?**_____

| | | |
|---|---|---|
| Y N Penicillin | Y N Tetracycline | Y N Sulfa |
| Y N Aspirin | Y N Dental Anesthetics | Y N Latex |
| Y N Erythromycin | Y N Codeine | Y N Other |

**Please list any other drugs that you are allergic to:** _____

_____

_____

**Have you been hospitalized in the last 5 years?** Y N

**Why?**_____

# 6 Dental History

**Have you traveled outside of the U.S. in the last 6 months?**

**If so when and where?** _____

_____

**Why have you come to the dentist today:** _____

_____

_____

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

**Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)** ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss?_____

How many times a day do you brush?_____

***DO YOU SMOKE*** ❑ Yes ❑ No

***DO YOU CHEW*** ❑ Yes ❑ No

**I understand that the administration of local anesthetic may cause an unfavorable reaction or side effects, which may include, but are not limited to, bruising; hematoma; cardiac stimulation; muscle soreness; and temporary or rarely, permanent numbness.**

**Payment is due in full at time of treatment unless prior arrangements have been approved.**

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

**I understand that the information that I have given today is correct to the best of my knowledge I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I also authorize this office to arrange credit for me if necessary. If my account should become delinquent, I will be responsible for all expenses involved in collection efforts, including attorney's fees, court costs, and collection agency fees if 30%.**

Signature_____

Date_____

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# Medical Information Release Form

**Name:**_____ **Date of Birth** _____

## Release of Information

___ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may released to:

___ Spouse _____

___ Child(ren)_____

___ Other _____

___ Information is not be to released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

## Messages

Please call ___ my home ___ my work ___ my cell number: _____

If unable to reach me:

___ you may leave a detailed message

___ please leave a message asking me to return your call

___ _____

The best time to reach me is (day) _____between (time) _____

Signed:_____ Date: _____

Witness:_____ Date:_____

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# AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize the health care provider named above to submit claims for payment for services to the health care service plans or insurance companies named below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

_____ _____

(DATE) (NAME OF PATIENT)

_____

(SIGNATURE OF PATIENT, PARENT OR GUARDIAN)

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# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the physician, dentist, or other health care provider named above to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate, or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective for up to five years from this date.

I know that I have the right to receive a copy of this authorization if requested.

_____ _____

(DATE) (NAME OF PATIENT)

_____

(SIGNATURE OF PATIENT, PARENT OR GUARDIAN)

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

**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)

_____

_____

_____