PATIENT INFORMATION

Name_____Birthdate_____SSN_____

Address_____City_____State_____Zip_____

Sex M F Married Y N Student Y N Email_____

Cell #_____ Home #_____Work #_____

Employer_____

Employer Addres_____City_____State_____Zip_____

How did you hear about us?_____Spouse or Parent's name_____

Emergency Contact (outside home)_____Phone#_____

RESPONSIBLE PARTY Person responsible

Name_____Birthdate_____SSN_____

Address_____City_____State_____Zip_____

Cell #_____ Home #_____Work #_____

Employer_____Email_____

INSURANCE INFORMATION

Name of Insured_____Birthday_____SSN_____

Relationship to patient_____Employer_____

Name of Insurance_____ID#_____Group#_____

Claims Address_____Phone#_____

SECONDARY INSURANCE

Name of Insured_____Birthday_____SSN_____

Relationship to patient_____Employer_____

Name of Insurance_____ID#_____Group#_____

Claims Address_____Phone#_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

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

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

_____

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 _____ DATE _____

We are excited that you have decided to join Greentree Dental family. The care of your oral health and well being is the number 1 priority of the dentists and staff of Greentree Dental. We hope that your experience far exceeds that of any other office that you have been to in the past. If there is anything that we can do to make your dental experience better, please let us know. In an effort to improve your experience here, the following are designed to make your visit smoother, more efficient, and put a smile on your face!

APPOINTMENTS

Unlike most offices, we do not overbook our schedule to anticipate cancellations or no-shows. We know that your time is just as valuable as ours.The time that we schedule for you is your special time reducing your time in the waiting area, in the treatment chair, and gets you going for the rest of your day in a timely manner.

We understand that emergencies may happen from time to time. When there is not a big last minute emergency, we ask that you talk to us about changing an appointment **no later than 24 hours before your appointment for every half hour of scheduled time.** There is a cancellation and rescheduling fee of $30.00 for every 30 minutes of cancelled or rescheduled appointment time. It can also be difficult if we need to move an appointment to a different time on the same day. Please help us keep the schedule on time and without last minute cancellations so we may continue to have your valuable appointment time set aside just for you. **INITIALS**_____

YOUR INSURANCE

In our current economy, it's becoming more and more difficult to keep dental insurance and almost impossible for individuals to even find good coverage. If you have any type of dental coverage, you have a great tool that can help with your dental care. We will do everything we can to get benefit information from your insurance company and help you understand how your insurance can help you. It is important to understand that **insurance is not meant to pay for all of your dental care, but act as a tool to reduce the amount you pay.** An insurance company may say that something is or is not covered, but it is not until they receive a claim from us that they will make a determination on your benefits. We will file claims for you with your insurance company, but we do ask that you **pay your deductible and copay or percentage at the time of your appointment**. We do our best to spend time with who is most important: You! **INITIALS**_____

IMPORTANT POLICIES

Greentree Dental has a returned check fee of $50.00 regardless of the amount of the check.

Requests from a patient for x-rays, charting and diagnostic aids remain the property of Greentree Dental. With a 10 day notice we can provide most items requested. Please note that there may be a charge to cover time, materials, and equipment.

If payment arrangements are defaulted, we reserve the right to recover collection costs, reasonable legal and attorney fees, court costs to settle the account, and interest of the unpaid balance at the rate of 18% APR. Copies of your credit report may need be obtained during this process to aid in the recovery of money.

Patient, Parent or Guardian Name _____ **Date**_____
(please print)

Signature_____

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's **Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

_____

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:_____