GRAND AVENUE
DENTAL STUDIO

PATIENT LAST NAME: ______________________________ FIRST: _______________________ INITIAL: _______

How do you wish to be addressed? ________________________________ Date of Birth ____________________

Address _____________________________ City _______________________ State _______ Zip _________

Telephone (Mobile) ____________________ (Work) _____________________ (Home) ____________________

Employer ____ How Long? ____________________

Email ____

How did you hear about our practice? ____

INSURANCE INFORMATION

Primary Insurance		**Secondary Insurance**	
Subscriber Name	________________________	Subscriber Name	________________________
Subscriber ID	________________________	Subscriber ID	________________________
Date of Birth	________________________	Date of Birth	________________________
Relationship to Subscriber	◯ Self ◯ Spouse ◯ Child ◯ Other	Relationship to Subscriber	◯ Self ◯ Spouse ◯ Child ◯ Other
Employer Name	________________________	Employer Name	________________________
Employer Phone	________________________	Employer Phone	________________________
Insurance Company	________________________	Insurance Company	________________________
Insurance Group	________________________	Insurance Group	________________________
Insurance Phone	________________________	Insurance Phone	________________________

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY (if minor)

Last Name: __________________________________ First: ____________________________ Initial: ________

Address (if different) ____ Date of Birth __________________

City ____ State _________________ Zip ________________

Telephone (Mobile) ____________________ (Work) _____________________ (Home) ____________________

Email ____

EMERGENCY CONTACT

Last Name: __________________________________ First: ____________________________ Initial: ________

Telephone (◯ Mobile ◯ Work ◯ Home) ____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less that the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPPA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text to 98269. Go to www.grandavedental.com for more information.

I attest to the accuracy of the information on this page.

Signature ____ Date ____________________
(Responsible Party, if under 18)

GRAND AVENUE
DENTAL STUDIO

Please complete all information. Thank you!

PATIENT LAST NAME: ______________________ PATIENT FIRST NAME: ______________________

DENTAL HISTORY

Reason for today's visit ____________________________________ Date of last dental visit ______________________

Former dentist_______ ____________________________________ Date of last dental x-rays ______________________

Please check if you have/had:

	Yes	No
Bad Breath	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on one side of mouth	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐
Smokeless tobacco	☐	☐
Dry mouth	☐	☐
Food collection between teeth	☐	☐
Clench or grind teeth	☐	☐
Growths or sore spots in your mouth	☐	☐
Gums swollen, tender, or bleeding	☐	☐

	Yes	No
Head, neck, jaw pain, or aches	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐
Orthodontic treatment	☐	☐
Nitrous Oxide	☐	☐
Periodontal treatment	☐	☐
Sensitivity to pressure or irritants (cold, heat, sweets)	☐	☐

How often do you floss? ______________________

How often do you brush? ______________________

Have you ever had an allergic reaction to Novocaine, local or general anesthetics? ☐ Yes ☐ No
If yes, please explain: ______________________
____

Have you ever been told you need to pre medicate for dental treatment? ☐ Yes ☐ No

Have you ever had trouble from previous dental care?
☐ Yes ☐ No If yes, please explain: __________
____
____

MEDICAL HISTORY

Physician's name ____________________________________ Date of last visit ______________________

Physician's address ____________________________________ Blood Pressure ______________________

Have you had any serious illness or operations Yes No If yes, please describe ______________________

Have you ever had bisphosphonate therapy Yes No If yes, give approximate dates ______________________

(Women) Are you pregnant? Yes No Due date ______________ Nursing? Yes No Taking birth control pills? Yes No

Please check if you have/had:

	Yes	No
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Joint ___________ Date ______	☐	☐
Joint ___________ Date ______	☐	☐
Asthma	☐	☐
Required hospitalization ________	☐	☐
Have you used steroids ________	☐	☐
Date of your last episode _______	☐	☐
Bleeding abnormality with operations or surgery	☐	☐
Blood thinners	☐	☐
Blood disease, clotting disorders	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes Type 1 Type 2	☐	☐
Dry mouth	☐	☐
Emphysema	☐	☐

	Yes	No
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Heart attack date ______________	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis Type ____________	☐	☐
Herpes	☐	☐
High blood pressure	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Pacemaker	☐	☐
Radiation treatments	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐

	Yes	No
Sickle cell anemia	☐	☐
Slow healing wounds	☐	☐
Stroke date ___________	☐	☐
Swelling of feet and ankles	☐	☐
Thyroid problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐
Weight loss, unexplained	☐	☐
Do you wear contact lenses?	☐	☐
Do you consume alcoholic beverages?	☐	☐
Are you currently under the care of a physician?	☐	☐
Are you allergic/sensitive to latex?	☐	☐
Allergic to Penicillin, Aspirin, or other drugs?	☐	☐

If yes, please specify ______________________
____
____

List any medications you are taking : ______________________
____
____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Parent/Guardian Signature ____________________________________ Date ______________________

Reviewed by ____________________________________ Date ______________________

General Consent Form

Medical History Information

Please understand that it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicines that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics, or other medications. Please be sure to provide us with a list of any drug allergies you have.

Restoration

I understand that care may be exercised in chewing on fillings until directed by doctor or staff to avoid breakage or soft tissue damage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that sensitivity may occur after a newly placed filling.

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 examination, for example, root canal therapy, following routine restoration procedures. I give my permission to Grand Avenue Dental Studio to make any/all changes and additions as necessary after consultation.

Complications

Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion may be permanent), reactions to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing, and treatment failure. The risks of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reactions, etc. (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). [It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may prescribe.] [Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other contraceptive measures be taken during the administration of antibiotics.]

X-Rays and Photos

Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentist with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. All patients 18 years and older will receive a full mouth series of intra-oral x-rays. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

Specific Problem Examinations

In the event that a patient requests only a specific problem be addressed (i.e. broken tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive exam will not be done. The dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a complete exam. You will not be considered a patient of record unless this examination is completed.

Minors

We must receive written consent prior to performing any non-emergency dental procedures on a minor. Grandparents, step-parents, friends, relatives, etc. are not legally allowed to consent to dental procedures, unless they have been given written consent by the parent of legal guardian. Please do not send your child to an appointment alone or with someone other than yourself unless you have filled out any necessary consent forms prior to the appointment, otherwise we may have no choice but to reschedule your child's appointment to another day.

Requests for Records/X-Rays

By law we are required to keep a patient's original x-rays and record in this office. Original x-rays or records will NOT be released. The patient or a designated person may request copies of their x-rays or record.

Specialty Referral and/or Second Opinion

General dentists perform the majority of all dental treatment today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases we may have to refer certain procedures out to a specialist. We would be happy to offer you the names of specialists in order for you to have a second opinion and/or have actual treatment performed by a specialist. I hereby authorize the dental staff of Grand Avenue Dental Studio to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, or court costs that may be incurred to satisfy this obligation.
I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to allow Grand Avenue Dental Studio to take x-rays and perform an examination on me today.

Parent or Guardian Signature

____

SECTION A: PATIENT GIVING CONSENT

Patient Name: ____

Address: ____

Telephone: ______________________ Email: ______________________

Patient Number: ______________________ Social Security Number: ______________________

SECTION B: TO THE PATIENT -- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether or not to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer: Kim Ulin
Phone: (405) 224-1311 ext 104
Address: 720 W. Grand Avenue, Chickasha, OK 73018

Right to Revoke: You will have the right to revoke the Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we receive your revocation.

SECTION C: PATIENT/RELATIVE HIPPA CONSENT

I, ______________________, understand that by signing this Consent form, I am giving my consent to Grand Avenue Dental Studio to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name: ______________________ Relationship: ______________________

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed on Section B.

______________________________ ______________________

Patient's Signature (Legal Guardian, if Patient is a minor) Date:

SECTION D: SIGNATURE

I, ______________________, have had full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature : ______________________________ Date: ______________

If this Consent is signed by a Personal Representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: ______________________ Relationship to patient: ______________

SECTION E: FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ◯ Individual refused to sign
- ◯ Communication barriers prohibited obtaining the acknowledgment
- ◯ An emergency situation prevented us from obtaining acknowledgment
- ◯ Other (please specify) ______________________

Signature : ______________________________ Date: ______________