Jennifer Grant Family Dentistry
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JENNIFER GRANT DDS

Full Medical History and Patient Information Packet

New patient appointments are **TWO** hours. Please let us know if this does not work **PRIOR** to appointment.

Patient Last Name: _____ Patient First Name: _____Date: _____

Is the patient a minor? **Y/N** If yes, parent name: _____ Patient SSN: _____

Patient DOB: _____ Age: _____ Marital Status: _____ **Mr./Ms./Mrs./Miss/Dr:** _____

Address: _____

Cell Phone: _____ Home Phone: _____ E-mail Address: _____

Confirmation by: **Text / Call / E-mail** Occupation: _____ Employer: _____

Whom may we thank for referring you? **Internet / Insurance / Family or Friend**: _____

Is anyone in the household a current patient of Dr. Grant? _____

Emergency Contact Name: _____ Relationship: _____ Number: _____

DENTAL INSURANCE INFORMATION

Dental Insurance Company: _____ Person Responsible for bill: _____

Insurance Subscriber Name: _____ Insurance Subscriber DOB: _____

Insurance Subscriber SSN: _____ Group No.: _____ Policy No.: _____

Patient's relationship to subscriber: **Self / Child / Spouse / Other** _____

DENTAL HISTORY

Current issues or concerns: _____

Date of last dental visit: _____ Last x-rays: _____ Former dentist: _____

Have you had trouble with any previous dental care? **Y/N** _____

Have you had periodontal treatment or a 'deep' cleaning: **Y/N** _____

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 DDS

MEDICAL HISTORY

Pharmacy: _____ Medical Doctor:_____ Physician's No.: _____

Have you had abnormal bleeding associated with previous extractions or surgery? _____

_____

Have you had any serious illnesses or operations? **Y/N** List here with dates: _____

_____

Please **CIRCLE** the following that apply:

AIDS **or** HIV +	Congenital Heart Disease	Nervous System Issues
ADHD	COPD	Nursing
Alzheimer's **or** Dementia	Depression	Osteoporosis **or** Osteopenia
Anemia	Diabetes: Type 1 **or** Type 2	Pacemaker
Anxiety	Emphysema	Persistent Cough
Arthritis: Osteo **or** Rheumatoid	Epilepsy	Pregnancy (Current)
Artificial Joints	Fainting	Psychiatric Care
Artificial Heart Valves	Glaucoma	Radiation to head/neck
Asthma	Headaches	Respiratory/Lung Disease
Autism	Heart Attack	Shortness of Breath
Autoimmune Disease	Heart Murmur	Sickle Cell Disease
Back Problems	Hemophilia	Sinus Trouble
Bisphosphonates	Hepatitis	Sleeping/Snoring Problems
Blood Thinners	High Blood Pressure	Steroid Treatment
Cancer	High Cholesterol	Stroke
Chemotherapy	Intellectual Disability	Swelling of Feet/Ankles
Chemical Dependency	Jaw Pain **or** Clicking	Thyroid Problems
Clotting Disorder	Kidney Disease	Tobacco Habit
Circulatory Problems	Liver Disease	Tuberculosis
Cold Sores/Fever Blisters	Mitral Valve Prolapse	Ulcers: Stomach **or** Mouth

Do you have a **disease**, **medical condition**, or any **other** information in regards to your general health not listed above? **Y/N** _____

_____

Current medications: _____

_____

_____

Drug allergies or **reaction** to any medications or metals? **Y/N** If yes, please list them: _____

_____

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/Guardian: **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.

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: ____

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: ____

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: ____

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: ____

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: ____

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: ____

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 not a guarantee 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 Legal Guardian Signature Date

_____ _____

Guardian Relationship to Patient Witness