



# GROVE DENTAL ASSOCIATES

## NEW PATIENT INFORMATION

### ABOUT YOU

Patient Name: \_\_\_\_\_  
(First) (Middle) (Last)

Mr.  Mrs.  Ms.  Dr. I prefer to be called: \_\_\_\_\_

Sex (check one):  Male  Female Birthday: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Phone #: \_\_\_\_\_

### SPOUSE INFORMATION

Mark if not applicable

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Birthday: \_\_\_\_\_

### DENTAL INSURANCE

*We will gladly assist you in filing the claims for your primary insurance if provided with the necessary information and a copy of the insurance card.*

Mark if not applicable Full Name of Policy Holder: \_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_ Policy Holder Employer: \_\_\_\_\_

Policy Holder Birthday: \_\_\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insurance Group #: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I understand that payment is expected on the day of each service. I realize I am also responsible for any remaining charges that my insurance company chooses not to pay.*

### REFERRED BY

Name of Referral: \_\_\_\_\_ Relationship to Referral: \_\_\_\_\_

Phone Book  Newspaper  Radio  Website  Facebook  Other

P : 9 1 8 . 7 8 6 . 5 5 3 3 F : 9 1 8 . 7 8 7 . 8 8 0 0	GROVEDENTALASSOCIATES.COM	5 7 H E F F E L M A N D R G R O V E O K 7 4 3 4 4
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# DENTAL HEALTH INFORMATION

When was your last dental visit? \_\_\_\_\_ Name of previous dentist: \_\_\_\_\_

Do you have any current dental issues or concerns you would like to discuss or address? \_\_\_\_\_

What (if anything) would you like to change about the appearance of your smile? \_\_\_\_\_

Do you have any fears about visiting the dentist (pain, cost, previously bad experience, lack of time, etc.)? \_\_\_\_\_

On a scale of 1 to 10 how would you rate your dental health? (1 being poor, 10 being excellent)

1    2    3    4    5    6    7    8    9    10

# MEDICAL INFORMATION

Name of Primary Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Any recent illness/doctor care or surgeries, please list: \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

Are you currently or have you ever taken any medication or bisphosphonates for osteoporosis?  Yes  No

All medical allergies: \_\_\_\_\_ Other allergies: \_\_\_\_\_

Have you been told that you require antibiotic pre-medication prior to dental treatment?  Yes  No Why? \_\_\_\_\_

Women: Pregnant?  Yes  No    Nursing?  Yes  No    Taking birth control pills?  Yes  No

Have you ever been treated for or experienced any of the following? (Please check all that apply.)

Sleep Disorder/Apnea    CPAP Therapy/Machine    Daytime Sleepiness    Acid Reflux    Clenching/Grinding of Teeth

Do you have a history of any of the following? (Please check all that apply.)

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> HIV Positive           | <input type="checkbox"/> Respiratory Disease     |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain               | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Scarlet Fever           |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Latex Allergy          | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Shortness of Breath     |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Back Problems          | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Nervous Problems       | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Blood Thinners         | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Thyroid Problem         |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Describe _____       | <input type="checkbox"/> Phen-fen or Diet Pills | <input type="checkbox"/> Tobacco Habit           |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Prolonged Bleeding     | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Ulcer                   |
| <input type="checkbox"/> Circulatory Problems   | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Radiation Treatment    | <input type="checkbox"/> Venereal Disease        |

Other: \_\_\_\_\_

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F : 9 1 8 . 7 8 7 . 8 8 0 0

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# GROVE DENTAL ASSOCIATES

## HIPAA FORM

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

- I HAVE BEEN OFFERED AND/OR RECEIVED A COPY OF GROVE DENTAL ASSOCIATES' NOTICE OF PRIVACY PRACTICES.
- I UNDERSTAND THAT MY PHI (PROTECTED HEALTH INFORMATION) CAN AND WILL BE USED FOR PURPOSES OF TREATMENT AND FOR PAYMENT FROM BOTH MYSELF AND/OR THIRD PARTY. I UNDERSTAND THAT I MAY REQUEST A COPY OF THE PRIVACY POLICIES AT ANY TIME.
- I UNDERSTAND I MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

**I GIVE CONSENT FOR THE OFFICE OF GROVE DENTAL ASSOCIATES TO SHARE PERSONAL INFORMATION REGARDING APPOINTMENTS, TREATMENT, BALANCE, ETC, WITH THE FOLLOWING FAMILY MEMBERS/ SPOUSE/FRIENDS/OTHER:**

**PLEASE LIST NAME/RELATIONSHIP AND SIGN BELOW:**

1. \_\_\_\_\_ / \_\_\_\_\_
2. \_\_\_\_\_ / \_\_\_\_\_
3. \_\_\_\_\_ / \_\_\_\_\_
4. \_\_\_\_\_ / \_\_\_\_\_
5. \_\_\_\_\_ / \_\_\_\_\_
6. \_\_\_\_\_ / \_\_\_\_\_

**PLEASE WRITE NO ONE IF YOU DO NOT WANT YOUR INFORMATION SHARED WITH ANYONE**

\_\_\_\_\_  
PRINT PATIENT NAME

\_\_\_\_\_  
PATIENT SIGNATURE  
OR PARENT/GUARDIAN SIGNATURE IF PATIENT IS A MINOR (UNDER 18)

\_\_\_\_\_  
DATE

P: 918.786.5533  
F: 918.787.8800

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