



GROVE DENTAL ASSOCIATES

ABOUT YOU

NEW PATIENT INFORMATION | MINOR CHILD

Patient Name: _____
(First) (Middle) (Last)

I prefer to be called: _____

Sex (check one): Male Female Birthday: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Social Security #: _____

Email: _____ School: _____ Grade: _____

PARENT/GUARDIAN INFORMATION

Father's Name: _____ Father's SSN: _____

Father's Employer: _____ Work #: _____ Cell #: _____

Mother's Name: _____ Mother's SSN: _____

Mother's Employer: _____ Work #: _____ Cell #: _____

Party Responsible for Payment (Full Name): _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____

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.

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#: _____ Birthday: _____ Employer: _____

Name of Insurance Company: _____

Insurance Group #: _____ Member ID#: _____

REFERRED BY

Name of Referral: _____ Relationship to Referral: _____

Phone Book Newspaper Radio Website Facebook Other

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

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DENTAL HEALTH INFORMATION

When was his/her last dental visit? _____ Name of previous dentist: _____

Does he/she have any current dental issues or concerns you would like to discuss or address? _____

What (if anything) would he/she like to change about the appearance of their smile? _____

Does he/she 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 his/her 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 he/she is currently taking: _____

All medical allergies: _____ Other allergies: _____

Have you been told this patient requires antibiotic pre-medication prior to dental treatment? Yes No Why? _____

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

Has this patient been treated for or experienced any of the following? (Please check all that apply.)

- | | | |
|--|---|---|
| <input type="checkbox"/> Habitual Teeth Grinding/Clenching | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Hyperactivity/Behavioural Issues |
| <input type="checkbox"/> Frequent Strep/Tonsillitis | <input type="checkbox"/> Sleep Disorder | |

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

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

Other: _____

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GROVE DENTAL ASSOCIATES

PEDIATRIC QUESTIONNAIRE

1. Does your child snore or breathe heavily at night? **Y/N**

If Yes....How often and how loud?

2. Do you notice your child breathing through their mouth?

3. Does your child grind his or her teeth?

4. Does your child move around or are they restless when they sleep?

5. Does your child seem hyperactive or have they been diagnosed with ADHD?

6. Does your child have any history of habits such as pacifier or thumb sucking, lip biting, etc?

7. Does your child have allergy issues or frequent sore throat/ear infections?

8. Does your child have any issues wetting the bed?

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57 HEFFELMAN DR
GROVE OK 74344



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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

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