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: 918.786.5533 F: 918.787.8800	GROVEDENTALASSOCIATES.COM	57 HEFFELMAN DR GROVE OK 74344

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.)

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

Other: _____

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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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