GROVE DENTAL
ASSOCIATES

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

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.)

☐ Habitual Teeth Grinding/Clenching
☐ Frequent Strep/Tonsillitis
☐ Acid Reflux
☐ Sleep Disorder
☐ Hyperactivity/Behavoiral Issues

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

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

Other: ____

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?

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

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	GROVEDENTALASSOCIATES.COM	57 HEFFELMAN DR GROVE OK 74344