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

P: 918.786.5533
F: 918.787.8800

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57 HEFFELMAN DR
GROVE OK 74344

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 ☐ Acid Reflux ☐ Hyperactivity/Behavoiral Issues
☐ Frequent Strep/Tonsillitis ☐ Sleep Disorder

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: _____

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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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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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