PATIENT REGISTRATION

GJS DENTAL GROUP

ID: _____ Chart ID:_____

First Name: _____ Last Name: _____ Middle Initial:_____

Patient is: ❑ Policy Holder ❑ Responsible Party Preferred Name:_____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial:_____

Address:_____Address 2:_____

City, State, Zip:_____ Pager:_____

Home Phone:_____Work Phone:_____Ext:_____Cellular:_____

Birth Date:_____Soc. Sec:_____Driver's Lic:_____

❑ Responsible Party is also a Policy Holder for Patient ❑ Primary Insurance Policy Holder ❑ Secondary Insurance Policy Holder

PATIENT INFORMATION

Address:_____Address 2:_____

City, State, Zip:_____Pager:_____

Home Phone:_____Work Phone:_____Ext:_____Cellular:_____

Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Birth Date:_____Soc. Sec:_____Driver's Lic:_____

E-mail:_____ ❑ I would like to receive correspondences via email

SECTION 2

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired

Student Status: ❑ Full Time ❑ Part Time

Medicaid ID:_____ Pref. Dentist:_____

Employer ID:_____ Pref. Pharmacy:_____

Carrier ID:_____ Pref. Hyg.:_____

SECTION 3 - Referral Source:

PRIMARY INSURANCE INFORMATION

Name of Insured:_____ Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec:_____Insured Birth Date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____

Rem. Benefits:_____.00 Rem. Deduct:_____00

SECONDARY INSURANCE INFORMATION

Name of Insured:_____ Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec:_____Insured Birth Date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____

Rem. Benefits:_____.00 Rem. Deduct:_____00

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MEDICAL HISTORY

PATIENT NAME_____Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physicians care now?	❍ Yes	❍ No	If yes, please explain:_____
Have you ever been hospitalized or had a major operation?	❍ Yes	❍ No	If yes, please explain:_____
Have you ever had a serious head or neck injury?	❍ Yes	❍ No	If yes, please explain:_____
Are you taking any medications, pills or drugs?	❍ Yes	❍ No	If yes, please explain:_____
Do you take, or have you taken, Fosamax or Bisphosphonate?	❍ Yes	❍ No	_____
Are you on a special diet?	❍ Yes	❍ No	_____
Do you use tobacco?	❍ Yes	❍ No	
Do you use controlled substances?	❍ Yes	❍ No	

Women: Are you
❑ Pregnant or trying to get pregnant? ❑ Nursing?
❑ Taking oral contraception?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics

❑ Other If yes, please explain:_____

Do you have, or have you had, any of the following?

❑ AIDS/HIV	❑ Chest Pains	❑ Frequent Headaches	❑ Irregular Heartbeat	❑ Scarlet Fever
❑ Alzheimer's Disease	❑ Cold Sores/Fever Blisters	❑ Genital Herpes	❑ Kidney Problems	❑ Shingles
❑ Anaphylaxis	❑ Congenital Heart Disorder	❑ Glaucoma	❑ Leukemia	❑ Sickle Cell Disease
❑ Anemia	❑ Convulsions	❑ Hay Fever	❑ Liver Disease	❑ Sinus Trouble
❑ Angina	❑ Cortisone Medicine	❑ Heart Attack/Failure	❑ Low Blood Pressure	❑ Spina Bifida
❑ Arthritis/Gout	❑ Diabetes	❑ Heart Murmur	❑ Lung Disease	❑ Stomach/Intestinal Disease
❑ Artificial Heart Valve	❑ Drug Addiction	❑ Heart Pace Maker	❑ Mitral Valve Prolapse	❑ Stroke
❑ Artificial Joint	❑ Easily Winded	❑ Heart Trouble/Disease	❑ Pain in Jaw Joints	❑ Swelling of Limbs
❑ Asthma	❑ Emphysema	❑ Hemophilia	❑ Parathyroid Disease	❑ Thyroid Disease
❑ Blood Disease	❑ Epilepsy or Seizures	❑ Hepatitis A	❑ Psychiatric Care	❑ Tonsillitis
❑ Blood Transfusion	❑ Excessive Bleeding	❑ Hepatitis B or C	❑ Radiation Treatments	❑ Tuberculosis
❑ Breathing Problems	❑ Excessive Thirst	❑ Herpes	❑ Recent Weight Loss	❑ Tumors or Growths
❑ Bruise Easily	❑ Fainting Spells/Dizziness	❑ High Blood Pressure	❑ Renal Dialysis	❑ Ulcers
❑ Cancer	❑ Frequent Cough	❑ Hives or Rash	❑ Rheumatic Fever	❑ Venereal Disease
❑ Chemotherapy	❑ Frequent Diarrhea	❑ Hypoglycemia	❑ Rheumatism	❑ Yellow Jaundice

Have you ever had any serious illness not listed above? ❍ Yes ❍ No If yes, please explain:_____

Comments_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature or Patient, Parent or Guardian_____ Date_____

GJS DENTAL GROUP

Informed Consent

Patient's Name: _____ Date of Birth: _____

A patient always has the choice of whether to proceed with any recommended treatment. Just as in medical procedures, a patient can refuse a diagnostic test, dental treatment or even dental x-rays.

But your dentist or dental hygienist cannot provide care for you based on an incomplete diagnosis without risking liability for failure to diagnose or treat existing conditions.

No patient can give consent for a practitioner to be knowingly negligent. So while you are free to refuse the treatment, your dentist or dental hygienist is also able to refuse to continue non-life-threatening dental treatment.

If you have a concern about dental x-rays, you should discuss the reason behind it with your dentist or dental hygienist. It may not change the need for dental x-rays but perhaps they can be done in a different way or a different number.

Cost is one concern that many patients have. If you have dental insurance, your insurance will often pay for dental x-rays—sometimes even more often than we want to take them! If you do not have insurance, ask if you could make payments on the x-ray portion of the day's cost or if you could postpone them to no later than your next visit to give you time to save up for the cost.

We work hard to make sure that the dental x-rays we recommend and take are necessary and will give us additional information to assist in your diagnosis and dental care. Dental x-rays are no longer a "one size fits all" recommendation of once every six months or once a year. We look at your health and the past history of cavities and gum disease as well as how vulnerable you might be to oral diseases. We do look at, but are not bound by, the American Dental Association's guidelines which were developed with input from both dental and non-dental groups. If your health circumstances change, you might see a difference in how often we recommend dental x-rays.

Some health and lifestyle events that might lead to more frequent taking of dental x-rays include (but are not limited to):

- Past history of cavities/cavity rate
- Periodontal disease (either active now or in your past)
- Tobacco use
- Systemic diseases that are known to affect teeth or gums (Ex. Diabetes)
- Medications that are known to affect mouths, teeth or gums.

Remember that we only see about 1/3 of your tooth and none of your bone when we look in your mouth. In most adults, we cannot examine the contact areas in between the teeth visually or with our dental instruments. Dental problems in an early state often **DO NOT** have symptoms such as pain or swelling that will signal something going on. But dental problems are most easily treated in an early stage, **BEFORE** symptoms develop.

We want to understand your position on dental x-rays, but we also ask that you understand ours and allow us to give you the care you deserve.

_____ _____

Signature of Patient, Parent, or Guardian **Date**

GJS DENTAL GROUP

GJS Dental Group

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of GJS Dental Group.The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties to this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

GJS Dental Group reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (PLEASE SPECIFY)	YES	NO

_____ _____

Name of Patient or Responsible Party Signature of Patient or Responsible Party

_____ _____

Date Description of Responsible Party's Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACHNOWLEDGEMENT NOT OBTAINED

Provided prior to treatment? Yes No

Date Provided:

Reason for Denial: Needed more time to review statement of Privacy Practices.
Wanted to consult with another person, before signing.
Unable to sign.
Reason not given.
Other (explain):

GJS DENTAL GROUP

Office Policy

GJS Dental Group

Dear Patients,

Thank you for choosing GJS Dental Group as your family dental provider. We look forward to providing you high quality dental care at an affordable price.

When scheduling your appointments, we are making a commitment to you. Please remember that we have reserved a special time for you. If you find a need to reschedule your appointment, we ask for a minimum of 48 hours notice. Failed appointments and canceled appointments without 48 hours notice are subject to an $85.00 fee.

Checks returned for insufficient funds are subject to a $35.00 fee. This fee is enforced to cover our bank charges. Please let us know if special arrangements must be made.

Patient portion is due at time of service. Please bring your co-payment with you.

We bill your insurance as a courtesy to you. If any amounts are denied or not covered, the balance owing is your responsibility. Your estimated patient portion for services is based upon the information provided by your insurance company, and is expected on the day treatment is rendered. Please ask for an estimate, if one has not already been given to you.

I declare that I am not a recipient of state assisted insurance, including but not limited to, DSHS. If I am, I am fully aware that the office will not bill DSHS nor are they a provider for DSHS.

Patient acknowledges in consideration for dental services to be rendered any outstanding debt to our office will not be included in any bankruptcy petition.

Unfortunately, we do not have the resources to maintain adequate supervision of children. Please refrain from bringing unattended/unscheduled children.

Thank you again for your understanding and care with helping to keep our facilities safe and clean and helping us provide you with the best possible dental care.

Patient
Signature:_____