THE DENTISTS AT GREENWAY
FAMILY AND COSMETIC DENTISTRY

Patient Information:

First Name: _____ MI: __ Last Name: _____ Title: _____

Nickname _____ Sex: _____ Marital Status: _____

Mailing Address: _____ Cell Phone: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Social Security #: _____ Birth Date: _____ Age: __ Work Phone: _____

Employer: _____ Occupation: _____

Student: _____ School: _____

Email: _____

Have you been a patient of our practice before: _____

Insurance Information (if different from above)**:**

Who is responsible for this account: _____

First Name: _____ MI: __ Last Name: _____ Title: _____

Mailing Address: _____ Home Phone: _____

City: _____ State: _____ ZIP: _____ Cell Phone: _____

Social Security #: _____ Birth Date: _____ Age: __ Work Phone: _____

Employer: _____ Occupation: _____

Spouse Name: _____ Occupation: _____

Referral Information:

Who referred you to our office: _____

General Dentist: _____ Office Phone: _____

Orthodontist: _____ Office Phone: _____

Physician: _____ Office Phone: _____

The Dentists at Greenway

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 physician's 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, Phen-Fen or Redux? ◯ 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/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

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 Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

THE DENTISTS AT GREENWAY
FAMILY AND COSMETIC DENTISTRY

GENERAL CONSENT FOR DENTAL TREATMENT

We are required to obtain your consent for contemplated or proposed dental treatment or oral surgery. Please read this form carefully and we encourage you to ask any questions you may have or if you need further explanation before. We will be happy to answer any and all questions. Before any treatment is rendered the Doctor will explain and ask permission before getting started.

1. I hereby authorize and direct The Dentists at Greenway, assisted by Licensed Dentists and/or Dental Auxiliaries of their choice to perform and assist upon me. The following dental treatment procedures (or oral surgery) including the necessary advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

2. In general terms, the dental procedures may include one or a number of the following:

a. Cleaning of teeth and application of topical fluoride

b. Application of sealants to the grooves of teeth.

c. Treatment of diseased or injured teeth with dental restorations. These restorations may either by amalgam (silver) or composite (white) material.

d. Stainless steel crowns for children. These are necessary in cases where simple fillings would not be the best long term restoration or in cases where there are large cavities.

e. The replacement of missing teeth with a dental prosthesis (crown, partials, etc)

f. Extraction (removal) of one or more teeth that cannot be saved.

g. Treatment of diseases or injured oral tissue (hard and/or soft).

h. Treatment of malaposed teeth.

Patient Name_____

Patients Signature _____ Date_____

FINANCIAL/APPOINTMENT POLICY

Our goal is to provide you with the best possible dental are for your wants and needs. All fees are disclosed to you before treatment is performed. Payment is due at the time services are rendered. We accept cash, checks, Visa/Mastercard and Discover. We can help you arrange financing through Carecredit. There is a $25.00 fee for any returned check. If you have dental insurance we will be happy to file your insurance claims for reimbursement and thus help you to receive your maximum allowable benefits.

Please note: Your insurance is a contract between you and your insurance company.

If you have insurance, please inform the office prior to being treated. This will allow plenty of time to get benefit information. Your insurance provider can also answer your questions you may have regarding coverage.

While the filing of claims is a courtesy we extend to our patients, all fees are your responsibility from the date services are rendered. If for any reason your insurance provider decides to deny benefits it will be your responsibility to pay for the outstanding balance. We allow 45 days from the date of submission for reimbursement. If payment is not received within the stated time frame, a statement will be sent directly to you for payment. All estimated co-pays are due at the time services are rendered.

We strive to make sure all scheduled patients are seen on a timely basis. All appointments are scheduled exclusively to fit your individual needs. Out of respect for our office and other patients, it is requested you give advance notice of cancellation. Please keep in mind a broken appointment could have been utilized by another patient in need of care.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO T HIS INFORMATION.

ACKNOWLEDGE OF RECEIPT:

I acknowledge that I have read and/or received a copy of The Dentists at Greenway Notice of Privacy Practices, General Consent Form for Treatment, and The Financial/ Appointment Policy.

X_____ DATE: _____

Dental History

Please check any of the following problems that apply to you:

- Sensitivity (hot, cold, sweet) ☐
- Where? (UR, LR, UL, LL) ☐
- Headaches, earaches, neck pain ☐
- Jaw joint pain ☐
- Teeth or fillings breaking ☐
- Grinding or clenching teeth ☐
- Bleeding, swollen, or irritated gums ☐
- Loose, tipped or shifting teeth ☐
- Bad breath ☐

If I could change my smile, I would:

- Make them whiter ☐
- Make them straighter ☐
- Close spaces ☐
- Replace black metal fillings with tooth colored restorations ☐
- Repair chipped/missing teeth ☐
- Replace old crowns that don't match ☐
- Have a smile makeover ☐

On a scale of 1-10, with 10 being the highest rating:

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

_____

Your last dental visit and name of previous dentist.

_____

_____

What is the most important thing to you about your dental visit today?

_____

_____

Are you interested in Orthodontic treatment?

_____

_____

Are you interested in bleaching/whitening trays?

_____

_____

How did you find out about our office? _____

Print Patient Name _____

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient
or Legal Representative _____ Date: _____

Witness: _____