Granbury Park Dental

500 W. Pearl Street
Granbury, Texas 76048
817-573-1141
www.granburyparkdental.com

Date: _____

Patient Name _____
Last First Middle Preferred Name

Address _____
Street City State Zip code

Home Phone_____WorkPhone_____Cell_____Best time to call_____

Email Address: _____ DL#_____ State _____

Social Security #:_____DOB _____Gender _____Martial Status _____

Pharmacy Name and phone _____Whom may we thank for referring you? _____

Employer Name _____Occupation _____

Insurance Information

Subscriber Name _____Subscriber Social Security # _____DOB_____

Insurance Company _____Phone _____

Employer Name: _____

Relationship to patient _____Subscriber ID #_____Group# _____

Emergency Information

Emergency Contact _____Phone number _____

Dental History

Reason for today's visit _____Date of last x-rays taken_____

Where? _____Date of last dental exam and professional cleaning _____

Do your gums bleed when you brush or floss? _____Has a dentist ever told you have gum disease? _____

Do you smoke, or use smokeless tobacco? _____ ***if yes, how often?*** _____

Is there anything you would like to change about the appearance of your teeth? _____ please explain _____

_____

Have you ever experienced an adverse reaction during, or in conjunction with a medical or dental procedure? _____

If yes, explain _____

Medical History

Physician Name _____Phone _____Are you in good health? _____

If no, explain: _____ Have you had any serious illness or operations? _____

If yes, explain: _____

Pleases list medications or herbal supplements you are currently take and reason for medication:

Medication	Condition	Medication	Condition

Do you currently have, or have you had any of the following? If yes, please check/circle

_____ Headaches/Migraines
_____ Heart Disease, Heart Murmur, Pacemaker
_____ High/Low Blood Pressure
_____ Blood Disease/ Circulatory Conditions
_____ Stroke/Heart Attack
_____ Artificial Joints / Heart Valves
_____ Taking Blood Thinners / Bisphosphonates
_____ Diabetes I or II
_____ Arthritis/Joint Pain
_____ Tumor/Cancer History
_____ Radiation/Chemo Treatment
_____ HIV / AIDS
_____ Seasonal Allergies/Hay Fever
_____ Menopausal / Hormone Therapy
_____ Wear Contacts
_____ Herpes / Cold Sores
_____ Memory Loss
_____ Parkinson's/ Multiple Sclerosis
_____ Auto-Immune Condition _____
_____ Dry Mouth/Bleeding Gums
_____ Hepatitis A/B/C
_____ Kidney / Liver Disease
_____ Asthma/Respiratory Conditions
_____ Tuberculosis/ Persistent Cough
_____ Medical Allergies:
____ Latex ____ Penicillin ____ Other Drugs
_____ Epilepsy/Seizures/Fainting
_____ Alcohol or Chemical Dependency
_____ Skin Reaction to Metal/Jewelry
_____ Osteoporosis/Osteopenia
_____ Depression/Anxiety
_____ History of Mental Disorders
_____ Thyroid Conditions
_____ Nervous Disorders
_____ Ulcers /Gout/ Stomach problems
_____ Hearing Loss
_____ Rheumatoid Arthritis / Lupus
_____ Sinus Issues / Cleft Lip or Palate
_____ Other Conditions NOT Listed:_____

(Women) Are you pregnant? _____ nursing? _____ on birth control? _____

I consent to dental procedures and anesthetics that are necessary for treatment. I understand I am accountable for knowing my insurance benefits and frequency limits. I consent to releasing my healthcare information to my insurance company to obtain payment. I agree I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date_____

If no changes on medical updates:

Date_____ Patient Signature: _____Clinical initials _____

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OFFICE AND FINANCIAL POLICY

We are pleased to have you as a patient and look forward to working with you in restoring and maintaining your dental health. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as easy and manageable for our patients as possible.

Payment is due at the time services are rendered. Please understand that we are not a financial institution. We do offer our patients the option of extended payment plans through CareCredit if approved in advance. We accept cash, personal checks, MasterCard, Visa, Discover, and American Express. (There is a $25.00 returned check fee.) We offer 3% accounting courtesy with a credit card, or a 5% accounting courtesy with a check or cash, to patients who pay their treatment balance 2 weeks in advance or more for treatment plans $1000 or more. We also offer a 5% courtesy for senior citizens that have treatment and pay in full (not including treatment involving lab cases).

As a courtesy to our patients, we will accept insurance assignment when all pertinent information is provided, and verification of coverage has been established. Diagnosis and treatment recommendations are made according to each individual patients' needs, and not in accordance with what your insurance will or will not cover.

While the filing of insurance claims is a service we provide for our patients, payment for treatment remains the sole responsibility of the patient or legal guardian of the patient who has been established as the responsible party. We will require that your deductible and any estimated co-pay/co-insurance percentages be made at the time of your visit. We will do our best to estimate what charges will be covered by your insurance company but understand that it is impossible for us to know the details of each individual policy. This office quotes current fee's that are within the usual and customary range of dental offices in our area. Many insurance companies pay from a set fee schedule that is often outdated.

Once final payment is received from your insurance, you will be billed for any remaining balance on your account. It is important to recognize that your insurance policy is an agreement between you, your employer, and your insurance company. Charges that should arise concerning coverage will be between the patient and their insurance company. If you have questions regarding your bill or your treatment, please feel free to consult with the office staff. Any account balances that are referred to a third-party agency for collections will be charged the fee for collections, and the patient understands they are solely responsible for all fee's incurred in the attempt to collect a debt.

Your appointment is reserved for you. If you must change your dental appointment, please provide us with a minimum of 24 business-hour notice of cancellation . Without a 24-business hour notice of cancellation you may be subject to a $75.00 no show/short notice cancellation fee or required to pre-pay for treatment prior to rescheduling future appointments, subject to the doctor's discretion.

I HAVE READ THE ABOVE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL OFFICE CHARGES. I ALSO UNDERSTAND THAT ONCE PAYMENT HAS BEEN RECEIVED FROM MY INSURANCE COMPANY, THE REMAINING BALANCE IS DUE ON MY ACCOUNT WITHIN 30 DAYS.

Signature of Responsible Party Date

Print Name of Responsible Party

Acknowledgement of Receipt of HIPAA & Electronic Communication Policies and Procedures

Granbury Park Dental

I give permission to the doctors and auxiliaries to use photographs, radiographs, and/or other diagnostic materials and treatment records for the purpose of teaching, research, or scientific publications, advertising, and social media.

A copy of our dental practice's privacy, security and breach notification policies and procedures are located on the wall across from the front desk or online at www.granburyparkdental.com.

I understand that I should ask our dental practice's privacy officer, Chari Brezel, if I have any questions about these policies and procedures.

I HAVE GIVEN PERMISSION FOR THE MEMBERS OF GRANBURY PARK DENTAL TO DISCUSS ANY MEDICAL/DENTAL CONCERNS, INCLUDING MEDICATIONS, TREATMENT, FINANCIAL, OR APPOINTMENT DETAILS TO THE FOLLOWING INDIVIDIUALS LISTED BELOW:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

List Your Email Address: _____ (Notify with any changes)

I acknowledge that the practice may send the following to my email address listed above:

Please Initial: _____ Information about my invoice, account balance, or financial concern

Please Initial: _____ Information about any dental appointments/visits

All electronic communication from our practice will be encrypted (secure)

By receiving our communication, you have agreed to store the information securely away from public use.

Print Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

Note: *If no one is listed we can only assume you do not give your permission to speak to anyone other than yourself regarding your medical/dental health or concerns.*