



General Patient Information

Date: _____

Patient Full Name: _____ Preferred Name: _____

Sex: ☐ Male ☐ Female DOB: _____ Age: _____ Social Security #: _____

Address: _____ City: _____ State: _____ ZIP: _____

Cell Ph#: _____ Home Ph#: _____ Email: _____

Referring Doctor: _____ General Dentist: _____

Orthodontist: _____ Physician: _____

Occupation: _____ Employer: _____

Name of School (If patient is over 18 y/o and a full-time student): _____ City: _____

Family members seen at this office: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Preferred Pharmacy: _____ Location: _____

RESPONSIBLE PARTY (FINANCIAL, IF DIFFERENT THAN PATIENT):

Full Name: _____ Sex: ☐ Male ☐ Female

DOB: _____ Social Security #: _____

Address: _____

City: _____ State: _____ ZIP: _____ Cell Ph#: _____

Home Ph#: _____ Email: _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT:

Emergency Contact: _____ Relationship to Patient: _____

Cell Ph#: _____ Home Ph#: _____ Email: _____

INSURANCE INFORMATION:

Primary Dental Insurance: _____ Insurance Ph#: _____

Insurance Address: _____

Employer of Policyholder: _____ Policyholder's Name: _____

DOB of Policyholder: _____ Relationship to Patient: _____

Policy ID # of Primary Dental Insurance: _____ Group ID#: _____

Secondary Dental Insurance: _____ Insurance Ph#: _____

Insurance Address: _____

Employer of Policyholder: _____ Policyholder's Name: _____

DOB of Policyholder: _____ Relationship to Patient: _____

Policy ID # of Secondary Dental Insurance: _____ Group ID#: _____

Primary Medical Insurance: _____ Insurance Ph#: _____

Insurance Address: _____

Employer of Policyholder: _____ Policyholder's Name: _____

DOB of Policyholder: _____ Relationship to Patient: _____

Policy ID # of Primary Medical Insurance: _____ Group ID#: _____

Secondary Medical Insurance: _____ Insurance Ph#: _____

Insurance Address: _____

Employer of Policyholder: _____ Policyholder's Name: _____

DOB of Policyholder: _____ Relationship to Patient: _____

Policy ID # of Secondary Medical Insurance: _____ Group ID#: _____

Patient/Guardian Signature: _____



Medical History

Name: _____

Height: _____ Weight: _____ Age: _____

MEDICATIONS (IF YOUR LIST IS EXTENSIVE, PLEASE ATTACH IT AT THE END):

Are you taking or have you ever taken any of the following?

☐ Blood Thinners

☐ Bone Density Medications/Bisphosphonates

☐ Sleeping Pills

☐ Diet Pills

☐ Narcotics

☐ Anti-Depressants

List any other medications you currently take:

ALLERGIES OR REACTIONS TO:

☐ Anxiety or Sleeping Medications

☐ NSAIDs (Ibuprofen or Aspirin)

☐ Local Anesthetics (Numbing Med.)

☐ Narcotics, Opiates, or Strong Pain Medication

☐ Antibiotics

☐ Soy or Eggs/Yolk

Please List:

☐ Others:

- What is the reason for this visit? _____
- Are you now under the care of a physician? ☐ Yes ☐ No
If yes, for what condition? _____
- Have you ever had any serious illness, operation, or hospitalization? ☐ Yes ☐ No
- Have you ever had any complication w/surgeries? ☐ Yes ☐ No
- Do you have unhealed/recurrent injuries, inflamed areas, growths, or sore spots in/around mouth?..... ☐ Yes ☐ No
If yes, describe where: _____
- Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? When? _____ ☐ Yes ☐ No
- Have you taken bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast®, Fosamax®, Boniva®, Actonel®, Aredia®, or Zometa®)?..... ☐ Yes ☐ No
What? _____ When? _____
- Are you taking any blood thinners? List: _____ ☐ Yes ☐ No
- Have you had any serious problems associated with previous dental treatment or general anesthetic? ☐ Yes ☐ No
If yes, please explain: _____
- Are you wearing contact lenses?..... ☐ Yes ☐ No
- Are you wearing removable dental appliances? ☐ Yes ☐ No
- Do you wish to talk with the doctor about anything privately? ☐ Yes ☐ No
- Do you have, **or have you had**, any of the following diseases or problems?
 - ☐ **Delay in Healing**
 - ☐ Currently Smoke or Chew Tobacco
How much for how long?: _____
 - ☐ Please check boxes that apply :
 - ☐ Marijuana Use ☐ Drug Use ☐ Alcohol Use
 - ☐ Damaged Heart Valves, Artificial Valves, or Heart Murmur
 - ☐ Chest Pain, Angina, Heart Attack(s)
 - ☐ Irregular Heartbeat
 - ☐ Cardiac Pacemaker
 - ☐ Stroke
 - ☐ High or Low Blood Pressure
 - ☐ Diabetes or Low Blood Sugar
 - ☐ Asthma, Lung Trouble, Chronic: Bronchitis, Cough, Difficulty Breathing
 - ☐ Fainting Spells, Seizures, Epilepsy
 - ☐ Hepatitis, Jaundice, or Liver Disease
 - ☐ Stomach Ulcers
 - ☐ Snoring or Sleep Apnea
 - ☐ Thyroid Problems
 - ☐ Arthritis or Painful, Swollen Joints
 - ☐ Kidney Trouble or Dialysis
 - ☐ Immunosuppressed
 - ☐ Sinus Trouble
 - ☐ Tumor or Growth
 - ☐ Neurological Disorder
 - ☐ Mental Health Problems (Include Depression)
 - ☐ Emotional Disorder
 - ☐ Eye Disease/Glaucoma
 - ☐ Abnormal Bleeding/Anemia
 - ☐ Blood Transfusion
 - ☐ Malignant Hyperthermia
 - ☐ Pain/Clicking of Jaws When Eating (TMJ)
 - ☐ Cancer and/or Chemotherapy
 - ☐ Radiation to Head, Neck, or Jaw
 - ☐ Sexually Transmitted Disease
 - ☐ Blood-Borne Disease

If any boxes above are checked, or any other conditions not listed, please explain in more detail below:

WOMEN ONLY:

☐ Pregnant/Trying to Become Pregnant

☐ Nursing

☐ Taking Birth Control Pills

*By submitting this document, I am hereby indicating that I have read and understand the above and answered the questions to the best of my ability. I understand that it is my responsibility to fill out this form correctly and completely. To falsify or omit information could seriously harm Dr. Anderson's ability to provide care safely.

Patient/Guardian Signature: _____



CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Granger Oral Surgery & Dental Implants to provide medical/dental evaluation, care, and/or treatment to me or someone for whom I am authorized to make medical decisions. This evaluation, care, or treatment is considered medically necessary and proper in the diagnosing or treatment of his/her/my physical condition. I understand that even though I give my consent for evaluation, care, or treatment, I may refuse any of these services at any time.

FINANCIAL POLICY STATEMENT

At Granger Oral Surgery & Dental Implants, we make every effort to provide you with the finest care and most convenient financial options. We will work to maximize your dental benefits for covered procedures. Payment is due at the time services are rendered. As a courtesy, we will file a claim with your dental benefit plan. Please remember that dental benefits are considered a reimbursement method for patient payments and are not a substitute for services rendered. If your dental benefit plan does not pay on your claim within 30 days from the date of service, you become responsible for any outstanding balance on your account.

We have opted out of the Medicare program and are not providers for Medicaid. If you have Medicare benefits, we ask that you let us know so you can sign a contract explaining in detail the terms of opt-out status.

In the event that the account is not paid in accordance with the financial arrangements made at discharge or within 90 days, the account will be turned over to a collection agency. The patient or responsible party will be responsible for all processing fees and collection costs, including reasonable attorney fees, if the account is placed in the hands of a collection agency or attorney.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize my insurance company to release all information necessary for payment of benefits. I hereby assign payment of benefits by my insurance company to Granger Oral Surgery & Dental Implants.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

A Notice of Privacy (NP) has been made available to me by Granger Oral Surgery & Dental Implants. The Notice of Privacy describes how my health information may be used or disclosed and my rights under the Health Insurance Portability and Accountability Act (HIPAA).

You may leave messages containing protected health information or finances on my voicemail: ☐ Yes ☐ No

I give permission for the release of account and health information to the following individuals:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

☐ I further authorize Granger Oral Surgery & Dental Implants to communicate with me electronically through the email address provided.

CONSENT FOR DIGITAL IMAGES

Dr. Anderson and the Granger Oral Surgery team may take photographs, videos, and/or digital records of my face, jaws and teeth before, during, and after treatment to be used for records, research, and education including lectures, seminars, demonstrations, professional publications such as journals or books or various electronic publications. I understand that if I consent, when the photographs, videos, and /or digital records are used, my name or other identifying information will be kept confidential and that I may revoke consent for obtaining and using future imaging in writing.

☐ I authorize use as stated above

☐ I authorize use as stated above with the following limitation: no full-face shot

☐ I do not authorize any publication of my photos, videos, and/or digital records

Patient Signature: _____

Signature of Financially Responsible Party: _____

(Parent or Guarantor)