What to expect at your first visit

Welcome to Grin.

To save you time at your first visit, complete the following forms before you arrive for your appointment.

The typical initial visit consists of the following:

- Review of primary dental concerns and past dental history
- Review of past medical history as many health conditions have significant bearing on your dental care
- Digital x-rays of teeth obtained [as x-rays outside of six months are too old for treatment planning]
- Laser detection of caries (“cavities”)
- Tooth-by-tooth examination with a small tooth-brush size video camera
- Oral cancer screening examination
- Periodontal examination for gum disease
- Discussion of dental needs and wants to create a directed plan to improve your dental health and smile
- The visit commonly takes 90 minutes

Many patients desire a dental cleaning at the time of their initial visit.

We try to provide this service whenever possible; however, some factors such as medical history or the nature of the cleaning that is required can prevent routine cleaning from being performed on the first visit.

New Patient Information

Personal Information

Today's date_____

First name_____ Middle initial_____ Last name_____

I prefer to be called _____ ☐ Male ☐ Female

Address_____City_____State_____ ZIP_____

Date of Birth_____ Social Security #_____

Cell Phone _____ Work Phone_____ Home Phone_____

Primary contact number (please check one) Please Select

Email_____ Employer_____

Spouse's name_____ Spouse's employer_____

Whom may we thank for referring you?_____

Are you currently a student ? School_____Grade/Year_____

Emergency contact person/ contact number_____

Dental Information

Reason for today's visit_____

Are you currently in pain? Please Select

If so, please describe_____

Do you have any dental problems right now? Please Select

If so, please describe_____

Have you ever had trouble with previous dental treatment? Please Select

If so, please describe_____

Anything we can do to improve upon your past dental treatments? _____

_____

Please rate your level of anxiety about seeing the dentist: (Least) 1 2 3 4 5 (Most) Please Select

Have you used nitrous oxide (laughing gas) for past treatment? Please Select

If not, would you be interested in trying nitrous oxide when having dental treatment completed ? Please Select

Are you interested in hearing about Sedation dentistry? Please Select

New Patient Information

Approximate Date of last cleaning _____

Procedure(s) done at last dental visit _____

Are you looking for a change in the way your smile looks? Please Select

If you could change anything about your teeth, it would be (check all that apply)

- ☐ Color of your teeth
- ☐ Size/Shape of your teeth
- ☐ Gaps between your teeth
- ☐ Too much or too little of teeth show when you smile
- ☐ Too much or too little gum shows when you smile
- ☐ Alignment of your teeth

Other _____

Do you have? (check all that apply)

- ☐ Sensitive or receding gums
- ☐ Missing teeth
- ☐ Teeth sensitive to heat/cold
- ☐ Concerns about bad breath
- ☐ Worn/broken/chipped teeth
- ☐ Old crowns that have dark edges at the top
- ☐ Teeth sensitive while chewing
- ☐ Old or discolored fillings

Other _____

Have you ever experienced ? (Select Yes or No for each)

Periodontal disease/gum treatment	Select	Discomfort in you jaw point (TMJ/TMD)	Select
Orthodontics treatment	Select	Your bite adjusted or balanced	Select
Oral surgery/ Wisdom Teeth	Select	Serious injury to the mouth or head	Select
A bite plate or mouth guard	Select	Chronic bad breath	Select
Snoring	Select	Grinding of teeth (day or night)	Select

If yes to any of the previous questions, please describe_____

_____

Do you require antibiotics before dental treatment? Select If yes, why? _____

_____

Have you ever taken, currently take, or plan to take medication for osteoporosis? (Bisphosphonates) Select

Is there anything else about your past dental treatment(s) that you would like us to know?_____

_____

_____

Grin DENTISTRY

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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ 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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ 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	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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 _____

Late Cancelation Policy

If you are unable to make your scheduled appointment,
contact us to reschedule at least **48 hours before**
to avoid the late cancelation fee of 55 dollars an hour.

When we do not receive a call with adequate time to change an appointment or a patient does not show up, it limits our ability to offer other patients a prime time appointment for necessary treatment.

Due to this office being closed on Fridays,
we require any cancelations for Monday Appointment on or before Thursday at noon.

CHARGES FOR CANCELLATION WITHOUT SUFFICIENT NOTICE AND FAILED APPOINTMENTS

$0.....*First missed appointment or cancellation with insufficient notice. You will receive a notice that you have used your one-time fee waiver for the cancellation.

$55.....*Second missed appointment or cancellation with insufficient notice.

$110.....*Third missed appointment or cancellation with insufficient notice.

$110.....*Subsequent missed appointments or cancellations with insufficient notice.

_____

SIGNATURE DATE

Office and Financial Policy

Our mission is to deliver the finest health care treatment available today. Following diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the investment in today's and future treatment.

Payment is due at the time services are rendered. For your convenience we accept cash, personal check, Visa, MasterCard, Discover and American Express. We also offer convenient payment options through CareCredit.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies may not pay for all your costs. Your insurance policy is a contract between you and your insurer.

As a courtesy we will be glad to file your claim for you provided we have complete and accurate insurance information. You will be expected to pay for services rendered if the office is unable to verify your insurance information prior to treatment. If payment for services already rendered has not been paid within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible. Should additional means of collection become necessary, all costs of collection, including attorney fees, court costs and collection agency fees (35% standard collection/50% legal collection) will be added to your existing balance. Your cooperation with this policy will assure equitable treatment of insured and non-insured patients.

We charge and collect fees for broken appointments.

Any accounts overdue for patient payment in excess of 45 days are subject to an interest fee of 18% per annum. A returned check fee of $35 will be added to your account balance for any checks returned to us as non-sufficient funds (NSF).

Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment.

I, the undersigned, authorize payment of the dental benefits otherwise payable to me, directly to Grin Dentistry.

I have read and understand this financial policy.

_____

SIGNATURE DATE

Photography Release

I _____, hereby authorize Dr. Malinda Mundy-Burgett to take photographs, slides and or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____

SIGNATURE DATE

Dental Insurance

Primary Carrier:

Insurance co. name_____Insured's I.D. no._____

Insurance Phone number_____

Insured's name_____Date of birth of Insured_____

Insured's employer name _____Relationship to patient_____

Secondary Carrier:

Insurance co. name_____Insured's I.D. no._____

Insurance Phone number_____

Insured's name_____Date of birth of Insured_____

Insured's employer name _____Relationship to patient_____

If the patient is a minor:

Name of parent or legal guardian and relationship_____

Is this parent or legal guardian currently a patient in our office? Select

HIPPA

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.
Please Print Name

_____

SIGNATURE DATE

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but, acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

_____

_____