GLEN VALLEY
DENTISTRY

PATIENT INFORMATION

Information for Minor Patient

Name: ____ Birth date______ / _______ / ___________

Address: _____________________________________ City __________________ Zip Code ____________

Home Phone: # (   ) _____ - _________   Cell Phone: # (   ) _____ - _________

Email: ____________________ @ _____________.______   SSN: _____ - ____ - _______

Responsible Party (Please fill out if different from above)

Responsible Party for Account: ______________________________

Relationship to Patient: ___________________

Billing Address: ____

City _________________________ State ______ Zip Code ___________

Phone Number: (   ) _____ - ________

E-mail: _____________________ @ __________. ______

I would like to confirm appointments with ◻ Text ◻ Email ◻ Automated Call

Whom may we thank for referring you?____

Dental Insurance Information

Name of Insured__________________________ Birth Date ___ / ___ /_____ Employer ________________

Relationship to Patient_____________________ Insurance Comp_________________________________

Insurance Phone # (   ) _____ - _________ Insurance ID# or SSN ___________________ Group #_________

Secondary Dental Insurance (if applicable)

Name of Insured__________________________ Birth Date ___ / ___ /_____ Employer ________________

Relationship to Patient_____________________ Insurance Comp_______________________________

Insurance Phone # (   ) _____ - _________ Insurance ID# or SSN___________________ Group #_________

MEDICAL INFORMATION

Patient Name ________________________
Name of Physician/ and their specialty ________________________
Most recent physical examination________________________ Purpose ________________________
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE OR HAVE YOU EVER HAD:	Y	N
1.Hospitalization for illness or injury __________		
2. An allergic or bad reaction to any of the following: ☐ Aspirin, ibuprofen, acetaminophen, codeine ☐ Penicillin ☐ Erythromycin ☐ Tetracycline ☐ Sulfa ☐ Local anesthetic ☐ Fluoride ☐ Chlorhexidine (CHX) ☐ Metal (nickel, gold, silver, _______) ☐ Latex ☐ Nuts ____________________________ ☐ Fruits ____________________________ ☐ Other____________________________		
3. Heart problems, or cardiac stent within the last six months		
4. History of infective endocarditis		
5. Artificial heart valve, repaired heart defect (PFO)		
6. Pacemaker or implantable defibrillator___________		
7. Orthopedic implant (joint replacement)		
8. Rheumatic or scarlet fever _____________		
9. High or low blood pressure _____________		
10. Stroke (taking blood thinners)		
11. Anemia or other blood disorder _____________		
12. Prolonged bleeding due to slight cut		
13. Pneumonia, emphysema, shortness of breath, sarcoidosis		
14. Chronic ear infection, tuberculosis, measles, chicken pox		
15. Asthma		
16. Breathing or sleep problems (i.e. sleep apnea, snoring, sinus)		
17. Kidney disease		
18. Liver disease		
19. Thyroid, parathyroid disease, or calcium deficiency		
20. Hormone deficiency		
21. High cholesterol or taking statin drugs		
22. Diabetes (HbA1c = ___________)		
23. Stomach or duodenal ulcer		

DO YOU HAVE OR HAVE YOU EVER HAD:	Y	N
24. Digestive or eating disorder (i.e. celiac disease, gastric reflux, bulimia, anorexia)		
25. Osteoporosis/osteopenia (i.e. taking bisphosphonates)		
26. Arthritis		
27. Autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)		
28. Glaucoma		
29. Contact Lenses		
30. Head or neck injuries		
31. Epilepsy, convulsions (seizures)		
32. Neurologic, disorders (ADD/ADHD, prion disease)		
33. Viral infections and cold sores		
34. Any lumps or swelling in the mouth		
35. Hives, skin rash, hay fever _______________		
36. STI/STD/HPV __________		
37. Hepatitis (type ____)		
38. HIV/AIDS ______________		
39. Tumor, abnormal growth		
40. Radiation therapy		
41. Chemotherapy, immunosuppressive medication		
42. Psychiatric treatment		
43. Antidepressant medication		
44. Alcohol/recreational drug use		
ARE YOU:	**Y**	**N**
45. Presently being treated for any other illness		
46. Aware of a change in your healthy in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)		
47. Taking medication for weight management		
48. Taking dietary supplements		
49. Often exhausted or fatigued		
50. Experiencing frequent headaches		
51. A smoker, smoked previously or use smokeless tobacco		
52. Often unhappy or depressed		
53. Taking birth control pills		
54. Currently pregnant		
55. Diagnosed with a prostate disorder		

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Parent/Guardian's Signature ____ Date____________

Name of Previous Dentist ____________________________How long were you a patient? __________

Date of most recent dental exam / / Date of most recent x-rays / /

Date of most recent treatment (other than a cleaning) / /

FINANCIAL AGREEMENT

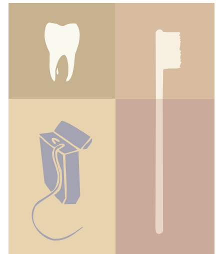
**RESPONSIBLE PARTY FOR ACCOUNT: PLEASE READ THE FOLLOWING & SIGN

For families, please include all patients on account

Patient Name(s): _________________________________

To our patients with insurance:

Please remember that your insurance coverage is a contract between you and your insurance company and is not a substitute for payment. If you would like a more accurate estimate of what your dollar portion will be for proposed treatment, we would encourage you to contact your insurance company for that benefit information. We will gladly submit your claim to your insurance company, but your portion is due the day of treatment. After receiving payment from your insurance company, you will then receive a bill from our office if there is any remaining balance. Payment is required within 15 days of notification.



To our patients without insurance:

We request that all charges be paid at the time of each visit.

**A $3.00 billing fee will be added to your balance if statements are sent out. If the account becomes past due and turned over to collections, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collections efforts. Your account being turned over to collections may result in you and anyone associated with this account being dismissed from the practice.

I understand and agree to the above policy: **X_______________________________** **Date: ___/____/ 20____**

Signature of Responsible Party on Account

HIPAA PRIVACY FORM

For families, please include all patients on account

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.**

DATE : ___ /___ / ______

PATIENT NAME: ____

Additional patient names if applicable: ____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: ____

DESCRIPTION OF AUTHORITY OF LEGAL REPRESENTATIVE: ____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ________________________________ Relationship ________________________________

Name: ________________________________ Relationship ________________________________