**GROVE PARK DENTAL PATIENT REGISTRATION**

**PATIENT INFORMATION**

NAME (first) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MI) \_\_\_ (last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B.\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ AGE \_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS [ ] single [ ] married [ ] divorced [ ] widowed         GENDER [ ] male [ ] female

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBERS (home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(work)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRAL SOURCE [ ] Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] family/friend\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] insurance [ ] website    [ ]phonebook   [ ] close to work/home   [ ] advertisement   [ ] other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSON RESPONSIBLE FOR BILL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER FAMILY MEMBERS SEEN HERE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

NAME OF FRIEND/RELATIVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**DENTAL INSURANCE INFORMATION** (If you do not have dental insurance, please skip.)

FOR VERIFICATION, PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK.

SUBSCRIBER INFORMATION (If other than patient)

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO PATIENT [ ] self   [ ] spouse   [ ] child   [ ] other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROVIDER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MEMBER ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP/PLAN ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize my insurance benefits to be paid directly to the dentist.  I understand I am financially responsible for any balance.  I also authorize Grove Park Dental or the insurance company to release information required to process my claims.

PLEASE INITIAL \_\_\_\_\_\_\_\_\_\_\_\_\_

--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

To the best of my knowledge, the questions on this form have been accurately answered.  I understand that it is my responsibility to inform the office of any changes in my personal or medical information.

**PATIENT NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under a physician’s care now? [ ] Y [ ] N **PHYSICIAN’S NAME AND PHONE #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any serious illness, been hospitalized or had a major operation? [ ] Y [ ] N **IF YES, EXPLAIN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a serious neck or head injury? [ ] Y [ ] N **IF YES, EXPLAIN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications, pills, or drugs? [ ] Y [ ] N **IF YES, LIST** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? **[ ] Y [ ] N**

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? **[ ] Y [ ] N**

Are you on a special diet? **[ ] Y [ ] N**

Do you use tobacco? **[ ] Y [ ] N IF YES, LIST PRODUCT AND FREQUENCY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use controlled substances? **[ ] Y [ ] N**

Are you allergic to any of the following? [ ] aspirin [ ] penicillin [ ] codeine [ ] local anesthetics [ ] acrylic [ ] metal [ ] latex

[ ] sulfa drugs [ ] other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN:** Are you- pregnant/trying to get pregnant? **[ ] Y [ ] N** taking oral contraceptives? **[ ] Y [ ] N** nursing? **[ ] Y [ ] N**

AIDS/HIV positive **[ ] Y [ ] N**

Alzheimer’s Disease **[ ] Y [ ] N**

Anaphylaxis **[ ] Y [ ] N**

Anemia **[ ] Y [ ] N**

Angina **[ ] Y [ ] N**

Arthritis/Gout **[ ] Y [ ] N**

Artificial Heart Valve **[ ] Y [ ] N**

Artificial Joint **[ ] Y [ ] N**

Asthma **[ ] Y [ ] N**

Blood Disease **[ ] Y [ ] N**

Cancer **[ ] Y [ ] N**

Chemotherapy **[ ] Y [ ] N**

Cold sores/Fever blisters **[ ] Y [ ] N**

Congenital Heart Disorder **[ ] Y [ ] N**

Diabetes **[ ] Y [ ] N**

Drug addiction **[ ] Y [ ] N**

Emphysema **[ ] Y [ ] N**

Epilepsy or seizures **[ ] Y [ ] N**

Fainting spells/Dizziness **[ ] Y [ ] N**

Heart attack/Failure **[ ] Y [ ] N**

Heart Murmur **[ ] Y [ ] N**

Heart Pacemaker **[ ] Y [ ] N**

Hemophilia **[ ] Y [ ] N**

Hepatitis A **[ ] Y [ ] N**

Hepatitis B or C **[ ] Y [ ] N**

Herpes **[ ] Y [ ] N**

High Blood Pressure **[ ] Y [ ] N**

High Cholesterol **[ ] Y [ ] N**

Hypoglycemia **[ ] Y [ ] N**

Irregular Heartbeat **[ ] Y [ ] N**

Kidney Problems **[ ] Y [ ] N**

Leukemia **[ ] Y [ ] N**

Liver Disease **[ ] Y [ ] N**

Low Blood Pressure **[ ] Y [ ] N**

Mitral Valve Prolapse **[ ] Y [ ] N**

Osteoporosis **[ ] Y [ ] N**

Parathyroid Disease **[ ] Y [ ] N**

Psychiatric Care **[ ] Y [ ] N**

Radiation Treatments **[ ] Y [ ] N**

Recent Weight Loss **[ ] Y [ ] N**

Renal Dialysis **[ ] Y [ ] N**

Shingles **[ ] Y [ ] N**

Sinus Trouble **[ ] Y [ ] N**

Stomach/Intestinal dis. **[ ] Y [ ] N**

Stroke **[ ] Y [ ] N**

Thyroid Disease **[ ] Y [ ] N**

Tuberculosis **[ ] Y [ ] N**

Tumors or Growths **[ ] Y [ ] N**

Ulcers **[ ] Y [ ] N**

What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental visit\_\_\_\_\_\_\_\_\_\_ last dental cleaning\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ last full mouth x-rays\_\_\_\_\_\_\_\_\_\_\_\_

**Check all that apply**

* How often do you brush?\_\_\_\_\_ floss?\_\_\_\_\_
* Are you satisfied with your teeth’s appearance?
* Have you noticed any mouth odors or bad tastes?
* Do you frequently get cold sores, blisters or any other oral lesions?
* Do your gums bleed or hurt?
* Have your parents experienced gum disease or tooth loss?
* Have you noticed any loose teeth or change in your bite?
* Does food tend to become caught in between your teeth? If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Would you like to keep all of your teeth, all of your life?
* Do you feel nervous about having dental treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Is there anything else about having dental treatment that you would like us to know? If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 my medical status.

.

 PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

* I hereby authorize Dr. Phuong-Uyen Le and Grove Park Dental’s designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_'s dental needs.
* Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as required to provide proper care.
* I agree to the use of anesthetics, sedatives and other medication as necessary.  I fully understand that using anesthetic agents embodies certain risks.  I understand that I can ask for a complete recital of any possible complications.
* I give consent to the use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care options.  I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Patient/Responsible Party’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE AND PRIVACY PRACTICES**

I acknowledge that I have received a copy of Grove Park Dental’s HIPAA Notice of Privacy Practices.  I also authorize the following person(s) to discuss my protected health information and treatment at this office:

[ ] none

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OR

Signature of Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authority of Personal Representative to sign for patient (check one):

[  ] parent     [ ] guardian     [ ] power of attorney     [ ] other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please note: It is your right to refuse to sign this Acknowledgement.**

Dental Office use only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

[ ] a communication barrier prevented us from obtaining acknowledgement

[ ] the individual was unwilling to sign

[ ] other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Member signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***![C:\Users\Op3\AppData\Local\Microsoft\Windows\INetCache\IE\KRPPX5N9\Italian_traffic_signs_-_fermarsi_e_dare_precedenza_-_stop.svg[1].png]()Financial Consent and Insurance Authorization![C:\Users\Op3\AppData\Local\Microsoft\Windows\INetCache\IE\KRPPX5N9\Italian_traffic_signs_-_fermarsi_e_dare_precedenza_-_stop.svg[1].png]()***

***Regarding Payment:***

We accept the following forms of payment:

-Cash

-Check

-Credit Cards- American Express, Visa, MasterCard, Discover and CareCredit.

* Payments for services are due at the time services are rendered unless prior arrangements have been made with our office.
* The parent that accompanies the minor child/children to the appointment is responsible for any payment due and **must be in attendance at all times in the waiting area while minor child/children are in treatment.**
* Balances older than 60 days may be subject to additional collection fees and interest charges may apply.
* Returned checks will have an **additional fee of $35.00** added to the amount of the returned check.
* **Minor child/children are not allowed in the operatory room unless they are having services rendered. Dental staff will not be responsible for any child/children left unattended in the waiting area.**

***Regarding Cancellations/Missed appointments:***

If a patient arrives more than **10 minutes late**, we will reserve the right to reschedule that appointment. Cancelling or rescheduling an appointment should be done within a 48 hours notice, a patient may be charged for the missed, cancelled and/or broken appointment at the rate of $50 per hour reserved. Please call the office as soon as possible if you have to reschedule. If more than 2 appointments have been delayed or cancelled last-minute, we will reserve the right to see the patient for same-day appointments only or dismiss patient from the dental practice

***Regarding Scheduling/Reserving appointments:***

Our staff at Grove Park Dental is committed to providing the highest quality of dental care and services for our patients. Dental procedures require preparation and planning. We reserve specific time blocks in an attempt to meet patient schedules and the urgency of the dental need. If you have made an appointment with us, that time has been reserved exclusively for you and we have prepared in advance for your visit. When scheduling your appointments, our office requires a reservation fee of half of your estimated co-payment for any treatment $200 or more. If your estimated co-payment is less than $200 our office requires a $50 reservation fee; and if less than $50 your reservation fee will be your estimated co-payment in full. All reservations fees are applied to your treatment, unless you have broken the appointment. At that time, a broken appointment fee will be applied and will be deducted from your reservation fee; this will only happen if you do not give the office 48 hours notice of cancellation. If you are unable to pay the reservation fee at the time of scheduling, we will not be able to schedule your appointment until it is collected.

***Regarding Records Release/Authorization:***

Copies of dental records may be released after the correct forms are completed and signed and the appropriate fee is paid. Electronic records (digital images and scanned paperwork) will be sent to an authorized email address free of charge. Printed records (copies) will be mailed (by post) to an authorized physical address or available for pick-up for $25.

***Regarding Insurance and Dental Benefits:***

**The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.**

 **As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for any questions regarding your benefits. Your insurance company and your plan benefits ultimately determine the payable amount. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.**

* All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
* Complete payment is due upfront for any and all treatment that has a deductible, co-payment, co-insurance and/or non-covered services, unless a Credit Card Pre-authorization Form is completed
* Patient is responsible for all charges for dental services and materials not paid by their dental benefit plan
* Patient allows use and disclosure of their protected health information to carry out any payment activities in connection with their claims
* Insurance payments are ordinarily received within 30-45 days from the time of filing a claim. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to make sure payment is expected. **If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.**
* Patient authorizes direct payment of the dental benefits to this office

**Please indicate your understanding and acceptance of these financial polices by signing below.**

**Our Dental Practice contact information:**

Name: Grove Park Dental

Privacy Official: Phuong-Uyen Le, D.M.D.

Mailing Address: 7123 N. Armenia Avenue, Tampa, Florida, 33604

Email Address: appt@groveparkdental.com

Phone Number: (813)932-7939

**Your contact information:**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I am authorizing Grove Park Dental to release the following Protected Health Information:**

[ ] dental report(s)

[ ] dental image(s)

[ ] other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The reason for the release of my Protected Health Information:**

[ ] patient request

[ ] treatment or continued care

[ ] other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I am requesting that Grove Park Dental release my Protected Health Information to:**

Organization name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person name or title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note: When your Protected Health Information is released as provided in this Authorization, the recipient may not have legal obligation to protect its confidentiality and may re-disclose it.

**Your rights with respect to this Authorization:**

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization. If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to Grove Park Dental to the mailing address or email address indicated above. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

By my signature, I certify that I have read and understand this Authorization. I am signing it voluntarily; I authorize the disclosure of my Protected Health Information as described in this Authorization.