Glenwood Dental
General & Cosmetic Dentistry

Patient Information

Date:_____ Home Phone: _____ Work Phone:_____Cell:_____

Name:_____ Social Security Number: _____- ____- _____ Email:_____

Address: _____City: _____ State: _____ Zip: _____

Sex: M ☐ F ☐ Birthdate:_____ ☐Minor ☐Single ☐Married ☐Widowed ☐Divorc

Patient Employed By: _____ Business Address: _____

Whom may we thank for referring you: _____

In case of emergency who should be notified: _____ Phone: _____

Responsible Party

Name of person responsible for the account: _____Phone:_____

Address of responsible party: _____City: _____ State: _____ Zip: _____

Relationship to the patient: _____ Birthdate:_____ SSN: _____ _____ _____

Dental Insurance Information

Name of the Insured:_____Relationship to Patient: _____

Insured's Date of Birth: _____ SSN: _____- _____- _____ Employer: _____

Insurance Company: _____ Phone: _____

Group Number: _____ Employee/Cert. Number: _____

Insurance Company Address: _____City: _____ State: _____ Zip: _____

Deductible: _____ Amount Already Used: _____ Maximum Annual Benefit: _____

Do you have Secondary Insurance Coverage: Yes ☐ No ☐ If yes, please complete the following information:

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ SSN: _____- _____- _____ Employer: _____

Insurance Company: _____ Phone: _____

Group Number: _____ Employee/Cert. Number: _____

Insurance Company Address: _____City: _____ State: _____ Zip: _____

Deductible: _____ Amount Already Used: _____ Maximum Annual Benefit: _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dent I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on n behalf or my dependents.

Signature of Patient or Parent if Minor:_____ Date: _____

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Dental History

Reason for today's visit: _____

When was your last dental visit: _____

How often do you brush your teeth: _____ What texture toothbrush do you use: Soft Medium Hard

Is there anything about your smile that you do not like: _____

What would you like to accomplish in your dental treatment: _____

Please circle an answer for **each question listed below:*

Do you have any old fillings or treatment that you are unhappy with: YES NO

Do your gums bleed while brushing: YES NO

Do your gums bleed when flossing: YES NO

Are your teeth sensitive to hot, cold, sweet or sour foods or liquids: YES NO

Have you noticed any loosening of your teeth: YES NO

Does food tend to become caught between your teeth: YES NO

Do you have any sores or lumps in or near your mouth: YES NO

Have you ever experienced any of the following problems in your jaw:

- Clicking YES NO
- Pain (joint, ear, side of face) YES NO
- Difficulty opening/closing YES NO

Would you like your teeth to be whiter: YES NO

Do you have frequent headaches: YES NO

Do you clench or grind your teeth: YES NO

Do you bite your lips or cheeks frequently: YES NO

Have you ever had:

- Orthodontic treatment (Braces): YES NO
- Oral Surgery: YES NO
- Your teeth reshaped or bite adjusted: YES NO
- Worn a night guard, bite plate or other appliance: YES NO

Are you satisfied with the appearance of your teeth and smile: YES NO

Have you ever had an upsetting experience in a dental office: YES NO

Is there anything about having dental treatment done that concerns you: YES NO _____

Medical History

Do you consider yourself to be in good health: YES NO

Have there been any changes in your general health within the past year: YES NO _____

When was your last physical exam: _____

Physician's name: _____

Address: _____

Telephone: _____

Are you currently under the care of a physician: YES NO

Have you ever been hospitalized for any surgical operation or serious illness: YES NO
If yes, please explain: _____

Are you currently taking any medication(s) including nonprescription medicine(s): YES NO
If yes, list here: _____

Have you had recent weight loss: YES NO

Are you currently taking diet pills or herbs: YES NO
If yes, list here: _____

Have you or are you currently taking osteoporosis medication such as Fosamax®: YES NO
If yes, list here: _____

Have you had any abnormal bleeding: YES NO

Do you bruise easily: YES NO

Have you ever required a blood transfusion: YES NO

Do you use tobacco: YES NO

Do you use alcohol: YES NO

Do you use cocaine or other drugs: YES NO

Are you wearing contact lenses: YES NO

Do you have any disease, condition, or problem not listed above that you believe I should know about: YES NO
If yes, please explain: _____

Are you allergic to or have you had reactions to:

- Local anesthetics: YES NO
- Penicillin: YES NO
- Sulfa Drugs: YES NO
- Barbiturates, Sedatives or Sleeping Pills: YES NO
- Aspirin: YES NO
- Iodine: YES NO
- Latex: YES NO
- Other Antibiotics: _____
- Other Allergies: _____

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Medical History Continued ...

Do you have, or have you ever had, any of the following:

Rheumatic heart disease or rheumatic fever	YES	NO	Diabetes	YES	NO
Scarlet Fever	YES	NO	AIDS or HIV Infection	YES	NO
Heart defect	YES	NO	Sinus Trouble	YES	NO
Heart murmur	YES	NO	Thyroid Problems	YES	NO
❑ Heart trouble ❑ Heart attack ❑ Angina	YES	NO	Allergies	YES	NO
Do you have pain in your chest upon exertion	YES	NO	Arthritis	YES	NO
Are you ever short of breath after mild exercise	YES	NO	Rheumatism	YES	NO
Do your ankles swell	YES	NO	❑ Joint Replacement ❑ Implant	YES	NO
Do you get short of breath when you lie down	YES	NO	Stomach Ulcer	YES	NO
Do you require extra pillows when you sleep	YES	NO	Kidney Trouble	YES	NO
Pacemaker	YES	NO	Tuberculosis	YES	NO
Heart Surgery	YES	NO	Persistent Cough	YES	NO
High Blood Pressure	YES	NO	Cough that produces blood	YES	NO
Low Blood Pressure	YES	NO	Cancer	YES	NO
Hepatitis A B C	YES	NO	Sexually Transmitted Disease	YES	NO
Jaundice	YES	NO	Epilepsy	YES	NO
Liver Disease	YES	NO	Anemia	YES	NO
Stroke	YES	NO	Leukemia	YES	NO
Lung or Breathing Problems	YES	NO	Eating Disorder	YES	NO
Asthma	YES	NO	**Women Only:**		
Hay Fever	YES	NO	Are you pregnant or think you may be	YES	NO
Hives or Skin Rash	YES	NO	Are you nursing	YES	NO
Fainting Spells or Seizures	YES	NO	Are you taking birth control pills	YES	NO

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.

Signature of Patient, Parent or Guardian _____ ***Date*** _____

FOR COMPLETION BY DR. OH & STAFF

Summary of Dental History: _____

Summary of Medical History: _____

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Financial Agreement

Dr. Oh and staff are committed to providing you with the best possible dental care. If you have dental insurance, we are anxious to help maximize your allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

PAYMENT: Fees are established according to services performed and payment is due at the time of service unless prior arrangements have been made. (If you have dental insurance, we require that you pay your estimated portion and deductible at the time of service.) A finance charge of 1% per month 12% per annum is assessed on any balance after 60 days.

INSURANCE PAYMENT: To prevent misunderstandings, we inform our patients that insurance policies vary and that it is each patient's responsibility to pay for the services rendered, regardless of individual coverage. (We accept cash, personal check, Visa, MasterCard, Debit, Auto Pay and outside patient financing through CareCredit). We are happy to process your insurance claim for you if all necessary filing information has been provided to us (ie. correct insurance information, correct social security numbers, group number(s), signed benefit claim form, etc.).

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that company.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Thank you for your understanding. Please do not hesitate to let us know if you have any questions or concerns.

I UNDERSTAND AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY.

Print Name:_____ Date:_____

Signature:_____ Date:_____

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Glenwood Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Glenwood Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐	**YES**	☐	**NO**
SPOUSE ONLY	☐	**YES**	☐	**NO**
OTHER (*PLEASE SPECIFY*):	☐	**YES**	☐	**NO**

_____
Name of Patient or Personal Representative

_____
Signature of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement Not obtained				
PROVIDED PRIOR TO TREATMENT?	**YES**	☐	**DATE STATEMENT PROVIDED: _____**	
	NO	☐		
REASON FOR NOT OBTAINING SIGNATURE			☐	**NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES**
			☐	**WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING STATEMENT**
			☐	**UNABLE TO SIGN**
			☐	**REASON NOT GIVEN**
			OTHER:	

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