The Ultimate Patient Experience
Glenwood PREMIER
IMPLANT • COSMETIC • FAMILY DENTISTRY

PATIENT

Patient's Legal Name:_____ Preferred Name:_____

Male Female Birth Date:____/____/____ SS#:_____ Email:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone (___)_____ Cell Phone (____)_____ Marital Status: Single Married Divorced

SPOUSE

Legal Name:_____ Birth Date:____/____/____ SS#:_____

Cell Phone:(____)_____ Employer:_____ Work Phone:(____)_____

DENTAL INSURANCE (PRIMARY)

Insured's Name:_____ Relation:_____

Insured's DOB:____/____/____ SS#:_____

Insured's Employer:_____ Insurance Company:_____

ID#:_____ Group#:_____

Insurance Company Address:_____

City:_____ State:_____ Zip Code:_____Phone #:(___)_____

DENTAL INSURANCE (SECONDARY)

Insured's Name:_____ Relation:_____

Insured's DOB:____/____/____ SS#:_____

Insured's Employer:_____ InsuranceCompany:_____

ID#:_____ Group#:_____

Insurance Company Address:_____

City:_____ State:_____ Zip Code:_____Phone #:(___)_____

CONTACT IN CASE OF EMERGENCY

Name:_____ Relation:_____

Phone #:(____)_____

I understand that the information I have given today is correct to the best of my knowledge I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status I authorize the dental staff to perform any necessary dental services that I (or the minor patient may need during diagnosis.

I understand I am responsible for payment of services at the time they are rendered if this office participates with my insurance, I understand I am also responsible to pay any co-payment and deductible at the time service is rendered

Patient_____ Date_____

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Full Name: _____ **Birth Date:** _____ **Today'sDate:** _____

Physician's (Medical Doctor) Name: _____

Are you allergic to any of the following?

___ Aspirin ___ Penicillin ___ Codeine ___ Latex ___ Local Anesthetics
___ Other (Please Specify) _____

Have you ever had or are currently experiencing any of the following diseases or medical conditions? (check all that apply)

- Pacemaker
- Heart Attack/Stroke
- High Blood Pressure
- Use/Carry Nitroglycerin
- Endocarditis (heart infection)
- Congenital Heart Defects (from birth)
- Heart Bypass or Stent
- Artificial Heart Valve
- Angina (chest pain)
- Daily Aspirin Baby
- Blood Thinners (Coumadin,Plavix,etc)
- Anemia/Leukemia
- Acid Reflux/Heartburn/GERD
- Cancer Type_____ Yr_____
- Radiation/Chemo
- Diabetes/Type
- Insulin Dependent
- Use Tobacco
- Anxiety/Depression
- Epilepsy/Seizure
- Osteoporosis
- Kidney concerns
- Thyroid disorder/concern
- Tuberculosis
- Hepatitis
- HIV or AIDS
- Sinus Concerns
- Seasonal Allergies/Hay Fever
- Asthma
- Eating Disorder(s)
- Rheumatoid Arthritis
- Fainting
- Bleeding Disorder
- Difficulty Hearing
- Alcoholism/Drug abuse
- Recreational Drugs
- Artificial Joints (hip,knee,etc) Date_____ Type _____
- Pregnant or Nursing

Please list hospitalizations (surgeries, emerg room) within the last year:

_____

I acknowledge that I have answered the above questions correctly and to the best of my ability. All my questions regarding this form have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

Medical Log

Date _____

Patient Name _____ Date of Birth _____

Pharmacy _____ Pharmacy Phone Number ( )

Please list ALL medications prescribed and taken on a regular daily basis.

Medication	Strength	Qty	Frequency	Reason for Medication

Please list ALL vitamins and supplements taking on a regular daily basis.

Brand Name	Strength	Qty	Frequency	Reason for medication

_____ _____

Patient Signature Date

To My Valued Patient Letter

To My Valued Patient,

This year marks the beginning of many exciting changes in my/our office in an effort to improve service and quality of care for you so that you can regain and maintain your health as quickly, efficiently, and inexpensively as possible. I have a purpose – and that purpose is to get sick people well and to prevent the well from getting sick. I also have a personal, professional, and ethical responsibility to care for your health to the best of my ability. Missed appointments, the failure to comply with recommended treatment schedules and/or procedures, as well as other important office policies prevent me from achieving my goal of optimum health for you. If you cannot keep your appointments, adhere to my treatment recommendations, and comply with these policies which I have set forth below for your benefit, I may not be able to continue treating you in good conscience. Therefore, the following policies must be agreed upon:

1. **Zero Balance office:** Our office operates on a financial policy of each patient having and maintaining no personal monies owed to us. Therefore, all of our patients must have a personal cash balance of zero at the time of treatment. In this office, we do not bill patients, we only bill insurance companies should you have dental coverage in which case we will accept assignment of benefits for this portion of your bill. This means that you will never receive a bill in the mail from our office since all payments not covered by insurance are handled directly with you in the office either at the time or in advance of service. We have several financial options for payment available to all of our patients including our own In-House Insurance Plan. Please speak to our Treatment Coordinator Samantha if you have any questions.
*Initials*_____

2. **No shows and late cancellations:** These are not acceptable. Failure to make an appointment or cancelling an appointment at the last minute not only compromises your health, but also inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot keep your scheduled appointment except in the case of an emergency, you are expected to call within 48 hours of your appointment to reschedule the appointment. There is a $150.00 fee for all no-show or late cancellation appointments, and this fee is not covered by insurance. All missed appointment fees are donated to Children's Miracle Network/Make-A-Wish Foundation.
*Initials*_____

3. **Lateness:** Timeliness is required and expected of all of our patients. We will see you on time and get you out on time unless in the rare occurrence of a delay prior to your appointment due to a legitimate patient emergency which required our immediate attention. If you are more than 10 minutes late for a scheduled appointment, you may be required to reschedule your appointment.
*Initials*_____

4. Missed Appointments: If you miss an appointment you must make it up and reschedule it within 24 hours whenever possible. It is critical to your health to do so to avoid any setbacks in the care and maintenance of your teeth and gums.
*Initials*_____

5. Cleanliness and Infection Control: These are of the utmost importance to us. We have the latest sterilization technology and disinfect each treatment room after every patient. This is another important reason we demand timeliness of ourselves and you. We request that you brush your teeth prior to being seated in a treatment room. Toothbrushes, paste, mouth rinse, and floss will be provided for you if needed. *Initials*_____

6. Insurance Coverage: Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Please be advised that insurance companies are not concerned about your health or well-being, but we are. We will provide you with an accurate estimate of benefits based upon our years of experience and interactions with your insurance carrier and based on your particular plan whenever possible. However, ultimately you are the one fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will or will not cover. It is also your responsibility to immediately inform us of any changes or loss of insurance coverage to assist us in helping you in any way possible, while at the same time ensuring that there no problems or conflicts which may occur as a result.
*Initials*_____

7. Referring Others to Our Practice: Our policy is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office. Please speak to our Office Manager/New Patient Coordinator Samantha about our Family Health Initiative Program/Friends and Family Program and other in-office patient referral rewards programs that we have available to our patients, their family, and their friends such as receiving a $25.00 gift card for every patient that you refer.
*Initials*_____

8. Upsets: It is our mission to ensure the complete satisfaction of all of our patients with the service and care they receive at our office. However, it is possible on occasion that there may be a misunderstanding or miscommunication between you and our office. We will do everything in our power to make things right by you should an upset occur provided you bring it to our attention in an appropriate, cordial manner at a time that we can give the matter the proper attention it deserves for effective resolution. You can expect that my staff will treat you with the same professional demeanor and efficiency as you would expect from them. Please see our Office Manager Samantha to resolve immediately any upsets you may have with me, my office, or one of my team.
*Initials*_____

9. Emergencies: It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency, you have our assurances that we will take care of you in a timely manner. In order to do this, we would like to define for you what a true emergency is. Swelling, bleeding, severe pain that has kept you up at night or requires medication, or a restoration in a visible area that falls out are all considered emergencies. If you have any of these symptoms we ask that you call us right away. We will provide you with the next available emergency appointment. We do set aside time each day for emergency visits.
*Initials*_____

I greatly appreciate your cooperation, and thank you again for choosing our practice for all of your dental health care needs.

Yours in Health,

Dr._____

_____ _____

Patient Office Manager

Patient HIPPA Awareness

With my permission, Glenwood Dental Group may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Glenwood Dental Group Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Glenwood Dental Group reserves the right to revise its Notice of Privacy Practices at any time. A revise Noticed of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Glenwood Dental Group may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Glenwood Dental Group may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. This also includes texting appointment reminders.

With my permission, the office of Glenwood Dental Group may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, I have the right to request the Glenwood Dental Group restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Glenwood Dental Group to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Print Name_____ Date_____

Signature_____