Grewal Dental Care
26597 N. Dixie Highway; Suite 169; Perrysburg, OH 43551 - (419) 872 3000 / (419) 872 3007

PATIENT REGISTRATION & FINANCIAL POLICY

Patient Name Sex: M F Birthdate Age

Home Address City State Zip

Please Circle One: Single Married Separated Widow Soc. Sec. #

Home Ph.# Cell Ph. # E-mail Address

Your Employer Work Ph. # How Long Employed

Are you a full time student? Yes No If patient is minor - Mother's DOB Father's DOB

Person responsible for Driver's License # Relation

Name of spouse (parent if minor) Spouse's (parent's) Soc.

Spouse's (parent's) Work Ph. # Cell Ph. #

EMERGENCY INFORMATION
Name, address, & telephone of a relative

Reason for visit

How did you hear about us?

DENTAL INSURANCE INFORMATION (Primary Carrier)			**If you have, complete this for the 2nd coverage**		
Insured's name			Insured's name		
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Phone #		DOB	Phone #		DOB
SS#	Group #	Local #	SS#	Group #	Local #

Thank you for choosing our office as your dental healthcare provider. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, Amex, MasterCard, Visa and Discover. Outside financing is available upon request and approval. Please ask if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees of $25. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges of $100 or 35% of the account balance, whichever is greater. If you default on your account, we have the option to report your account status to any credit reporting agency.

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however the **ESTIMATE IS NOT A GUARANTEE THAT YOUR INSURANCE WILL PAY EXACTLY AS ESTIMATED**. Your insurance and your plan ultimately determine the amount paid. We will do all we can to make sure your estimate is as accurate as possible.
- 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, your employer, and your insurance company. Our office is not a party to that contract.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance at the time of service.
- Insurance payments are ordinarily received within 30-60 days from time of filing. If payment has not been made within 60 days, we ask that you contact your insurance. If payment is not received or your claim is denied, you are responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- There may be certain insurances for whom we may choose not to process claims for. In those cases, we expect you to pay us fully and completely at the time of the service. The processing of the claims for those insurances will solely be your responsibility.
- On treatment involving crown and bridgework, dentures, root canals, etc., that require longer than an hour appointment, you agree to put in a deposit of at least 50% of the dental fee of your co-insurance/deductible payment before the treatment is rendered for you.
- The balance on your statement is due and payable when the statement is issued, and is past due if payment is not received within 30 days.
- Finance charge will be imposed on each item of your account which has not been paid within 30 days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of 2% per month or an ANNUAL PERCENTAGE RATE of 24% percent. The finance charge is computed by applying the periodic rate (2%) to the “overdue balance” of your account at the end of each month.
- We do white (composite resin) fillings for all adult teeth. Please be aware that **your insurance company may not pay for a composite resin filling at the same level as a silver (amalgam) filling. Any portion not paid by your insurer is your responsibility.**
- As a courtesy, no cancellation fee will be charged the first time a patient cancels an appointment with less than 24-hour notice. If such a cancellation occurs a second time, $35 fee may be charged. No-shows (w/o 24-hr notice) or cancellation-in-office will incur a $35 charge.
- In case of divorce/separation, parent accompanying child & authorizing treatment is responsible for the charges. If the divorce decree requires other parent to pay all/part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent.

Consent: **I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.** I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose.

Patient Signature (Parent signature if child is patient) _____ Date _____

Patient Name _____ **Health History Form**

Please check any of the following problems that apply to you

	YES	NO
Sensitivity (hot; cold, sweet, pressure) Where? UR LR UL LL	☐	☐
Headaches, earaches, neck pain	☐	☐
- Jaw joint pain	☐	☐
- Teeth or fillings breaking	☐	☐
- Grinding or clenching teeth	☐	☐
- Bleeding, swollen or irritated gums	☐	☐
- Loose, tipped or shifting teeth	☐	☐
- Bad breath	☐	☐
Do you have or had any of the following?		
- Dentures	☐	☐
- Partial Dentures	☐	☐
- Braces	☐	☐
- Periodontal (gum) treatments	☐	☐

	YES	NO
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco?	☐	☐
How much? _____ For how long? ____		
If I could change my smile, I would:		
- Make it whiter	☐	☐
- Make it straighter	☐	☐
- Close spaces	☐	☐
- Replace black metal fillings with tooth colored restorations	☐	☐
- Repair chipped teeth	☐	☐
- Replace missing teeth	☐	☐
- Replace old crowns that don't match	☐	☐
- Have a smile makeover	☐	☐

Please share the following dates:

- Your last cleaning _____ / _____
- Your last oral cancer screening _____ / _____
- Your last complete X-Rays _____ / _____

Name of Previous Dentist _____

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

City _____ State _____ Phone Number _____

Why did you leave your previous dentist? _____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY (Check any that apply)

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS			Dizziness			HIV Positive			Scarlet Fever		
Allergies (Seasonal)			Drug Addiction			HPV (Human Papilloma Virus)			Seizures		
Anemia			Emphysema			Jaundice			Sinus Problems		
Angina (Chest pain)			Epilepsy			Jaw Joint Pain			Sleep Apnea		
Arthritis			Excessive Bleeding			Kidney Disease			Stomach Problems		
Artificial Heart			Fainting			Liver Disease			Stroke		
Artificial Joints			Glaucoma			Low Blood Pressure			Thyroid Disease		
Asthma			Heart Conditions			Mitral Valve Prolapse			Tuberculosis		
Blood Disease			Heart Lesions			Nervousness/Depression			Ulcers		
Bruise Easily			Heart Murmur			Pacemaker			Venereal		
Cancer			Heart Surgery			Pregnant Currently			Others		
Cervical Cancer			Hepatitis A			Radiation (head/neck)					
Chemotherapy			Hepatitis B			Respiratory Problems					
Cortisone Med.			Hepatitis C			Rheumatic Fever					
Diabetes			High Blood Pressure			Rheumatism					

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO
Aspirin	☐	☐	Percodan	☐	☐	Tetracycline	☐	☐	Valium	☐	☐
Darvon	☐	☐	Latex	☐	☐	Codeine	☐	☐	Penicillin	☐	☐
Nitrous Oxide	☐	☐	Local Anesthetic	☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐

Other _____

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	☐	☐	Zometa	☐	☐
Aredia	☐	☐	Boniva	☐	☐
Fosamax	☐	☐	Herbal	☐	☐
Reclast	☐	☐	Supplements	☐	☐

Are you under a physician's care? What for?

What medications are you currently taking? Family Physician / Number?

Consent: The undersigned herby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature (Parent signature if child is patient) **Date** **Dentist Signature**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****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}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship

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 acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____