GRIFFITH Family Dental

PATIENT REGISTRATION 2022

Today's Date: _____

Patient Name _____ **SEX: M** ⬭ **F** ⬭

Home Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

SS# (required) _____ Birth Date _____

I am: Married Single Child of Subscriber

Home # _____ Cell #_____ Work # _____ x _____

Email _____

May we remind you of your appointments by text and email? ⬭ Yes ⬭ No

Patient Employer _____

Person responsible for Account **Check if same person** _____

Name _____ **SEX: M** ⬭ **F** ⬭

Address _____ **City** _____ **Zip** _____

Relationship to Patient _____ **Birth Date** _____

Employer _____ **Work #** _____ **x** _____

DENTAL HISTORY

Reason for today's visit? _____ **Prior Dentist?** _____ **Last Visit?** _____

Place a check mark to indicate you have had any of the following:

Bad Breath	___ Y	Bleeding Gums	___ Y
Blisters on lips or mouth	___ Y	Smoker	___ Y
Burning sensation on my tongue	___ Y	Grinding Teeth	___ Y
Orthodontics/Braces	___ Y	Jaw Pain	___ Y
Chew on one side of mouth	___ Y	Periodontal issues	___ Y
Gums swollen and tender	___ Y	Pain around ear(s)	___ Y
Jaw Clicks/Pops	___ Y	Mouth breathing	___ Y
Fillings Loose or broken	___ Y	Lip/cheek biting	___ Y
Sensitivity to heat	___ Y	Food collects in teeth	___ Y
Sensitivity to cold	___ Y		
Sensitivity when biting	___ Y	I brush _____ times per day.	
Sores/Growths on mouth	___ Y	I floss _____ times per day.	

Please circle your level of dental anxiety: None Low Medium High

Health History 2022

Check if you have had any of the following:

AIDS/HIV	___ Y	___ N	Heart Stint	___ Y	___ N
Anemia	___ Y	___ N	Hepatitis A / B / C	___ Y	___ N
Arthritis/Rheumatism	___ Y	___ N	Herpes	___ Y	___ N
Artificial Heart Valve	___ Y	___ N	Hyperthyroidism	___ Y	___ N
Lupus	___ Y	___ N	Hypothyroidism	___ Y	___ N
Asthma	___ Y	___ N	Jaundice	___ Y	___ N
Back Problems	___ Y	___ N	Jaw Pain	___ Y	___ N
Blood Disease	___ Y	___ N	Kidney/Liver Disease	___ Y	___ N
Blood Pressure High	___ Y	___ N	Dialysis	___ Y	___ N
Blood Pressure Low	___ Y	___ N	Organ Transplant	___ Y	___ N
Blood Thinner Meds	___ Y	___ N	Mitral Valve Prolapse	___ Y	___ N
Cancer	___ Y	___ N	Neck Problems	___ Y	___ N
Chemical Dependent	___ Y	___ N	Nervousness	___ Y	___ N
Chemotherapy	___ Y	___ N	Osteoporosis/Bone Disease	___ Y	___ N
Cholesterol HIGH	___ Y	___ N	Pacemaker	___ Y	___ N
Cortisone Treatment	___ Y	___ N	Psychiatric Care	___ Y	___ N
Defibrillator	___ Y	___ N	Radiation Treatment	___ Y	___ N
Diabetes	___ Y	___ N	Respiratory Issues	___ Y	___ N
Epilepsy	___ Y	___ N	Rheumatic Fever	___ Y	___ N
Excessive Bleeding	___ Y	___ N	Sinus Problems	___ Y	___ N
Fainting	___ Y	___ N	Stomach Problems	___ Y	___ N
Glaucoma	___ Y	___ N	Stroke	___ Y	___ N
Headaches	___ Y	___ N	Tuberculosis	___ Y	___ N
Head Injuries	___ Y	___ N	Tumor	___ Y	___ N
Heart Disease	___ Y	___ N	Ulcers	___ Y	___ N
Heart Murmur	___ Y	___ N	PTSD	___ Y	___ N
Joint Replacement	___ Y	___ N	Are you pregnant?	___ Y	___ N
Dizziness	___ Y	___ N			

Other _____

Are you currently under the care of a physician? Yes ____ No ____

Dr Name _____ **Phone #** _____

List ALL Medications you are taking - If you need addt'l space, please use the back of this sheet.

_____

_____

Preferred Pharmacy _____ **Phone** _____

Address _____

Emergency Contact _____ Relationship _____ Phone _____

Circle if you have ALLERGIES to: Aspirin Codeine Iodine Penicillin Latex
Amoxillin Clindamycin None

Other _____

Dental Insurance Assignment 2022

We must have the following information for insurance and billing purposes only.

Subscriber Name _____ Subscriber DOB _____

Subscriber Employer _____ SS# _____

Primary Insurance _____ ID#_____ Group#_____

Provider Phone# listed on your Insurance Card _____

Are you a Federal employee? No ☐ Yes ☐

If you are a Federal employee, who is your medical insurance? _____

Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ .

(Insurance Company)

By signing below, I authorize James L. Griffith DDS, or any provider associated with Griffith Dental, LLC aka Griffith Family Dental, to disclose / use my personal healthcare information and/or that of my family to my/our insurance companies and their agents for the purpose of obtaining payment or obtaining pre-determination of benefits.

I assign and authorize all insurance payments to be made directly to James L. Griffith, DDS or any provider associated with Griffith Family Dental and/or Griffith Dental LLC and/or one of its assignees, for services rendered.

_____ _____

Signature of Patient, Guardian or Legal Representative **Date**

2022 FINANCIAL POLICIES

a) We do not file Secondary insurance except for Federal employees.

b) We will make every effort to explain your treatment needs and costs to avoid any misunderstandings. **However, we can never guarantee the amount your insurance will pay. You will be responsible for paying all fees that are not paid by your insurance company, no matter the reason.**

Initial _____

c) You must keep us informed of any changes with you and/or your family's insurance.

d) We accept M/C, Visa, American Express, Discover Card, Cash, Check and Care Credit. You are responsible for paying all co-insurance, co-payments, deductibles, and estimated fees the day services are rendered.

e) Balances older than 30 days will be subject to interest charges of 1.5% per month.

f) **After 90 days, if payment is not made on your account, formal action to collect will be initiated through a collection agency**. At that point, the guarantor or patient will be subject to an immediate charge of up to 25% of the balance as a collection fee as well as any other fees incurred as a result of being sent to Collections.

Initial _____

g) Returned checks will incur a $45 charge.

h) **It is our POLICY for you to provide A SOCIAL SECURITY NUMBER for all patients 18 years and older.**

Initial _____

APPOINTMENT POLICIES

a) Each appointment is **RESERVED** for you or your family member and we strive to see everyone on time.

b) If you need to change an appointment, please call us **at least** 48 hours before the scheduled time. **Appointments canceled with less than 48 HOURS NOTICE,** are subject to a **$75 Broken Appointment Fee.**

c) Monday appointments must be canceled by the preceding Thursday.

d) Children, under the age of 18, must always be accompanied by an adult.

e) All patients who are eighteen (18) years of age are considered adults by law. Federal HIPAA laws FORBID Griffith Dental, LLC aka Griffith Family Dental to discuss treatment or billing with parents or guardians without a signed HIPAA consent from the patient.

I acknowledge and agree that payment is due at the time of service. I authorize payment of benefits to James Griffith DDS, or any provider associated with Griffith Dental, LLC aka Griffith Family Dental.

_____ _____ _____ _____

Signature Date Griffith Dental Employee Date

Personal Health Information RELEASE FORM to FAMILY MEMBERS

According to the Federal Government's **H**ealth **I**nformation **P**ortability and **A**ccountability **A**ct (HIPAA), we are mandated to keep all personal and medical information private for our patients. Patients who are eighteen (18) years of age are considered adults and HIPAA privacy includes and protects them.

Unfortunately, this means a patient's treatment and fee information must be kept confidential from family members, such as husbands, wives, sons, daughters, etc. UNLESS the Patient authorizes Griffith Dental LLC aka Griffith Family Dental to discuss their protected health information with them, specifically.

If, YOU, the Patient, want to allow access by another person (or persons) to YOUR account, please complete the following, giving Griffith Dental permission to share.

I, _____, DOB: _____ authorize Griffith Dental, LLC and/or Griffith Family Dental and any employee of the practice to provide the following CIRCLED information:

1) Everything in my Chart **3) Treatment Prescribed**

2) Treatment Completed **4) Financial Details** to the following people:

Name _____ Phone # _____ Relationship _____
Name _____ Phone # _____ Relationship _____
Name _____ Phone # _____ Relationship _____

I understand that I can rescind authorization to any, or all, of these individuals at any time.

_____ _____

Signature of Patient Date

_____ _____

Signature of Griffith Dental Employee Date

2022 Consent and Release of Use and Disclosure of HEALTH INFORMATION

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this NOTICE.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

By signing this form, you consent to our use and disclosure of your Protected Health Information to carry out treatment, payment activities and health care operations. If there is not a copy of this notice accompanying this Consent Form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

We reserve the right to change our Notice of Privacy Practices. If we do, we will issue a revised notice.

You may obtain a copy of Our Notice of Privacy Practices, including any revisions of our Notice, at any time by calling our office.

Right to Revoke: You have the "Right to Revoke" this consent at any time by giving us written notice. Please understand that revocation will not affect any action we took in reliance on this Consent *before* we received your revocation. However, we will require payment in full or may decline to treat you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent & Release for Use and Disclosure of Health Information. I understand that by signing this Consent Form, I am giving my consent to Griffith Dental, LLC aka Griffith Family Dental and its assignees to use and disclose any of my Protected Health Information, or that of my family, to carry out treatment, payment activities and health care operations, including sending PHI to Specialists to whom I seek treatment.

Print Name _____

Patient/Guardian Signature _____ **Date** _____

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For Office Use Only

We have attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained from this individual because:
Individual refused to sign acknowledgement form _____ or
Communication barriers prohibited obtaining acknowledgement _____