PATIENT REGISTRATION 2018

Patient First Name _____ Last Name _____

SEX: **M** ⬭ **F** ⬭ Date of Birth _____

Home Address _____ City _____St_____ Zip _____

Social Security # (required) _____

I am the: Subscriber ____ Married ____ Single ____ Dependent _____ F/T Student ____ Married to Subscriber ____

Email _____ Cell _____Home _____

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

Patient Employer _____ Work Phone _____

Employer Address _____

DENTAL HISTORY

Reason for today's visit? _____

Name of prior Dentist? _____ **Date of 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.	
		I floss _____ times per day.	
Sores or growths on mouth	___ Y		
Mouth pain when brushing	___ Y		

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Health History

Medical Doctor's Name_____ Phone# _____

Check "**Y"** or **"N"**to indicate you have or had any of the following:

Allergies to: Amoxicillin ___ Aspirin ___ Codeine ___ Iodine ___ Penicillin ___
Clindamycin ___ Other _____

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	Hyper-thyroidism	___ Y	___ N
Artificial Joints	___ Y	___ N	Hypo- thyroidism	___ Y	___ N
Asthma	___ Y	___ N	Jaundice	___ Y	___ N
Back Problems	___ Y	___ N	Jaw Pain	___ Y	___ N
Blood Disease	___ Y	___ N	Kidney Disease	___ Y	___ N
Blood Pressure High	___ Y	___ N	Liver Disease	___ Y	___ N
Blood Pressure Low	___ Y	___ N	Lupus	___ 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/Dizziness	___ 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	Other _____		
Joint Replacement	____ Y	___ N	Are you pregnant?	____ Y	___ N

List ALL Medications you are taking _____

_____

Name and Phone # of your Pharmacy: _____

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Dental Insurance Assignment 2018

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 800# on Insurance card _____

Are you a Federal employee? No ☐ Yes ☐

Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
(Insurance Company)
and assign all insurance benefits directly to James L. Griffith, DDS or any provider associated with Griffith Family Dental and/or Griffith Dental LLC.

I understand that I am financially responsible for all charges, **including those not paid by my insurance company** and authorize the use of my signature on all insurance submissions.

Furthermore, I agree James L. Griffith DDS, or any provider associated with Griffith Dental, LLC aka Griffith Family Dental may 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 for services or for obtaining pre-determination of benefits for services.

_____ _____

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

Who can we thank for your referral to us? _____

Emergency Contact: _____ Phone_____

Relationship to Patient: _____

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2018 FINANCIAL POLICIES.

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

Initial "I Understand" _____

b) You must keep us informed of any changes with you and your family's insurance benefits.

c) 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 fees the day services are rendered.

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

e) **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 Collection.

Initial "I Understand" _____

f) Returned checks will incur a $35 charge.

g) WE MUST HAVE A SOCIAL SECURITY NUMBER for all patients 18 years and older. If not, you or the patient will be asked to make full payment on the day of service.

Initial "I Understand"_____

h) **As of April 1, 2018, we will no longer file Secondary insurance except for Federal employees.**

APPOINTMENT POLICY

a) Each appointment time is RESERVED for a certain patient and we strive to see everyone on time.

b) If you need to change an appointment, please call us **at least** 24 hours before the scheduled time. **Appointments canceled with less than 24 HOURS NOTICE,** are subject to a **$50 Broken Appointment Fee.**

c) Monday appointments must be canceled by Friday at 12 pm noon.

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 waiver from the patient. You will find the waiver in this paperwork.

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 and/or one of its assignees, for services rendered, under the terms of my insurance policy. I have read, understand and accept the terms stated above.

_____ _____

Signature Date

_____ _____

Signature of Griffith Dental Employee Date

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 _____

Communication barriers prohibited obtaining acknowledgement. _____

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2018 Consent and Release of
Use and Disclosure of HEALTH INFORMATION

NAME _____ DOB _____ Relationship to patient _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose: 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.

Notice of Privacy Practices:

a) You have the right and we encourage you, to read our Notice of Privacy Practices before you sign this consent.
b) The Notice of Privacy Practices provides a description of:
    - treatment activities and health care operations
    - the use and disclosures we may make with your Protected Health Information,
    - important information about your protected health information.
c) 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.

Patient's Name (Print) _____ Date _____

Signature of Patient or Guardian _____

……

Revocation

I revoke my Consent for your disclosure of my protected health information for treatment, payment activities and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand you may decline to treat me and that I must pay for services on the day they are rendered after I have revoked my Consent. **Patient must WRITE explanation on back of this form.**

I UNDERSTAND I MUST PAY FOR MY TREATMENT ON THE DAY PERFORMED.

_____ Date _____

Signature for Revocation

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HIPAA AUTHORIZATION 2018

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

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

Should YOU, the Patient, want to allow access to YOUR account to another person or persons, please complete this form.

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

_____ Treatment Needed

_____ Treatment already Completed

_____ Fees

_____ Everything in my Chart

to the following people:

1) _____ Phone # _____ Relationship _____

2) _____ 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