Welcome

Patient Information

Dr. Groll and his staff would like to thank you for choosing our practice for your dental needs. If you have any questions about this form please do not hesitate to ask. We would be happy to help you.

(Please Print)

Patient Name ______________________ SS# ______________ Date __________

Prefers to be called ____________________ Who Referred you to our office? ____________

Patient Date of Birth ______________________ Gender: Male Female

Patient Physical Address ____________________ City ________ State ____ Zip ______

Mailing Address ________________________ City ________ State ____ Zip ______

Home Phone # ________________________ Work # ________ Cell # __________

I agree to receive text and e-mail messages for scheduling and billing purposes from our office? **YES NO**

E-mail Address ______________________________

Do prefer to receive calls at: Home Work Cell Are you: Single Married Divorced Widowed

Patient Employer ______________________ Employer Phone # ________________

Patient Employer Address ____________________ City ________ State ______ Zip: ______

Emergency Contact ____________________ Phone # __________ Relationship __________

Parent/Spouse Name ____________________ Phone # __________ Work # ____________

Parent/Spouse Employer ____________________ Phone # ________________

Responsible Party

Name of responsible person ______________________ Relationship ______________

Address ______________________ City __________ State ________ Zip ________

Name of Employer ________________________ Work # __________________

Patient Employer Address ____________________ City ________ State ______ Zip: ______

Date of Birth ________________________ SS# ________________________

Email Address: __________________ Home Phone: __________ Cell Phone: __________

Insurance Information

Primary Insurance (Use your Identification card)

Name of Insured:________________________ Relationship to Patient: ____________

Address: ____________________________ Phone Number: ________________

Date of Birth: ______________________ Social Security #: ____________________

Home Phone #: __________________ Cell Phone #: ________________________

Name of Employer: ____________________ Work Phone #:____________________

Insurance Company: __________________ ID #:______________ Group # __________

Insurance Address: ________________ City: __________ State: ________ Zip: ________

Insurance Company Phone #: ____________________ Payor ID #: __________________

Secondary Insurance (Use your Identification card)

Name of Insured:________________________ Relationship to Patient: ____________

Address: ____________________________ Phone Number: ________________

Date of Birth: ______________________ Social Security #: ____________________

Home Phone #: __________________ Cell Phone #: ________________________

Name of Employer: ____________________ Work Phone #:____________________

Insurance Company: __________________ ID #:______________ Group # __________

Insurance Address: ________________ City: __________ State: ________ Zip: ________

Insurance Company Phone #: ____________________ Payor ID #: __________________

OFFICE CONSENTS, FINANCIAL POLICIES & FEDERAL TRUTH –IN-LENDING STATEMENT

I, the undersigned, hereby authorize the office of Dr. Shawn R Groll to place images in my chart for patient identification purposes. I grant permission for before and after pictures of my teeth and face and/or my minor's teeth and face. By signing this authorization I waive any claims of breach of privacy pertaining to the release of any photographic or digital images. I acknowledge that I have received a copy of the privacy policies of this office.

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the cost incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and the he/she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1.5% per month or (18% APR) on the unpaid balance will be assessed on all accounts exceeding 60 days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of 6 months from the date of the patient examination. In consideration for the professional services to be rendered to me, or at my request, to my minor child or ward by the dentist, I agree to pay fees charged for all dental services provided to the dentist or his/her assignee at the time the services are rendered, or costs and collection agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account including charges billed, payments made, and interest charges assessed, etc. to Dr. Shawn R. Groll's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or my work place to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member. I authorize the use of my mobile phone number as listed in this document to receive scheduling and billing messages. I agree to update this office if my mobile number changes.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize Dr. Shawn R Groll or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's privacy. I agree to disclose to Dr. Shawn R Groll the names of any individual(s) with whom I authorize Dr. Shawn R Groll to discuss my dental care.

I understand if I **EVER** request copies of my x-rays or records there will be a $20 Charge

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

____ ____________________

Signature of Patient, Parent, or Guardian Date

____

Relationship to Patient

CONSENT TO PROCEED

I authorize Dr. Groll and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:____

Signature:______________________________ Date:______________

(Patient, legal guardian or authorized agent of patient)

Witness:______________________________ Date:______________

OFFICE PRIVACY POLICIES

THIS NOTICE describes the privacy policies of this dental office. This office strives to maintain confidentiality as far as your dental treatment information. In this summary we describe how this confidential dental and health information is used and disclosed and how you can gain access to this confidential information.

BACKGROUND INFORMATION

We are required by applicable law to maintain confidentiality of dental health information generated for patients during the course of treatment. We are required to notify all patients about our privacy practices and your rights concerning your health information. These office privacy policies take effect as of April 14, 2003 and will remain in effect until amended by this office. We reserve the right to change the privacy practices of this office and the terms of this notice at any time provided that such changes are permitted by applicable law and we will make you aware of any changes we make. Our patients are welcome to request copies of our office privacy policies at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

TREATMENT: We may use or disclose your dental health information to dental colleagues, your physician or other health care providers rendering treatment.
PAYMENT: We may use and disclose your dental treatment information through regular mail, fax, or electronic transmission to your dental insurance carrier to obtain payment for services rendered. Limited treatment information may also be disclosed to billing services which assist the office in preparing monthly billing statements.
DENTAL PRACTICE OPERATIONS: We may use and disclose your health information in conjunction with our health care operations.
YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment, or dental practice operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.
DISCLOSURE TO FAMILY AND FRIENDS: You have the right for us to disclose your own personal dental health information.
PERSONS INVOLVED IN CARE: We may use or disclose dental health information to identify or assist in the identification of you or a family member in conjunction with a forensic investigation.
MARKETING: We will not use your dental health information or images of your face and/or teeth for marketing communications without your specific written authorization to do so.
SUBPOENA: We may use or disclose your health information when we are required to do so by law through subpoena.
ABUSE OR NEGLECT: We may disclose dental information of minor patients to appropriate authorities if we have reason to believe that they are possible victims of abuse, neglect or domestic violence or the possible victim of other crimes.
APPOINTMENT REMINDERS: We may use or disclose basic dental information insofar as the fact that you have a dental appointment scheduled in the form of appointment reminders such as voicemail messages, postcards, letters or e-mail messages.

PATIENT RIGHTS

ACCESS: You have the right to read over or obtain copies of your dental health information, with limited exceptions. Utah law (R-156-69-502(7) specifies that original records must remain in possession of the treating dentist for seven years, but you may request copies for nominal fee.

QUESTIONS AND COMPLAINTS: If you want additional information about our privacy policies or have questions or concerns, you should contact our privacy officer. If you believe or are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your dental health information, you may complain to us by using the contact information listed at the end of this notice.. You may correspond with the U.S. Department of Health and Human Services. We will provide you with the address of the U.S. Department of Health and Human Services upon request.

Office Address: 26 West Main Hyrum, Utah 84319
Office Telephone: (435) 245-5866
Office Fax: (435) 245-5869

Office Address: 275 No. Main Randolph, Utah 84064
Office Telephone: (435) 793-2210
Office Fax: (435) 793-2444

Signature: ______________________ Date: ____________

Family Members: ______________________

____

Patient Name

Patient Account No.

Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? ______________________

Date of Last Dental Visit ________ **Last Dental Cleaning** ________ **Last Full Mouth X-rays** ________

What was done at your last dental visit? ______________________

Previous Dentist's Name ______________________

Address ______________________ State ________ Zip ________

Telephone ______________________

How often do you have dental examinations? ______________________

How often do you brush your teeth? ________ How often do you floss? ________

What other dental aids do you use? (Interplak, toothpick, etc.) ______________________

Do you have any dental problems now? Yes No

If yes, please describe: ______________________

Are any of your teeth senstive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? ______________________

Do you:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleeping disorders? Yes No

Smoke/chew tobacco or use other tobacco products? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause ______________________

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? ______________________

Have you ever had an upsetting dental experience? Yes No

If yes, please describe ______________________

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe ______________________

(Please complete other side)

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MEDICAL HISTORY

Patient Name	
Patient Account No.	**Medical Alert**

1. Have you been under the care of a medical doctor during the past two years? .... Yes No
   If yes, for what? ______
   Physician's Name ______ Phone ______
   Address ______ City ______ State______ Zip______
2. Have you taken any medication or drugs during the past two years? .... Yes No
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? .... Yes No
   If yes, please list name and dosage ______
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimen (fenfluramine); and Redux (dexfenfluramine)? .... Yes No
   If yes to the above, did you have a medical exam for heart issues? .... Yes No
5. Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? .... Yes No
   If yes, please list: ______
6. Have you been a patient in the hospital during the past five years? .... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you use more than two pillows to sleep? .... Yes No
9. Have you lost or gained more than 10 pounds in the past year? .... Yes No
10. Do you have or have you had any disease, condition, or problem not listed? .... Yes No
    If yes, please list: ______
11. **Women:** Are you pregnant or think you may be pregnant? Yes, ____ Months No **Nursing**? Yes No
12. **Women:** Do you use birth control medications? .... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature______ Date ______

History Review

Dentist Signature______ Date ______

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