PATIENT INFORMATION

Gray Dental Associates
Dr. Kara Moore, DMD
Dr. Molly Smith, DMD

First Name _____ **Last Name** _____

Preferred Name_____ **Cell Phone** _____

Date of Birth _____ **Social Security Number** _____**Gender:** Male/ Female

Street Address_____ **City**_____ **State** _____ **Zip Code**_____

Email Address_____

Previous Dentist_____ **Last dental cleaning** _____

Current dental issue_____

Is the patient a minor? Yes/No

Name of custodial parent(s)

1._____

2._____

Responsible party (This must be the person signing the form) _____

Please list the names of people who have permission to bring the minor to their appointments.

1._____

2._____

3._____

INSURANCE INFORMATION

Dental Insurance Provider

_____

Dental Insurance Phone Number

_____

Are you a dependent

_____

Policy Holder Name

_____

Policy Holder DOB _____

Policy Holder Social Security Number

_____

Member ID #

_____

Group #

_____

Employer

_____

MEDICAL HISTORY FORM

Circle what applies to you

Pregnant
Osteoporosis
Heart Disease
Autoimmune Disease
Prolonged Bleeding
High/Low Blood Pressure
Lung Disease/Asthma/TB
Emphysema
Hepatitis
Diabetes
Hypoglycemia
Aids/HIV
Allergies (other than meds)
Neurological
Kidney Disorder
Glaucoma
Stomach Problems
Irregular heartbeat/Atrial fibrillation
Had Local Anesthesia
Sensitive Teeth
Pain/Popping in Jaw
Regular Headache
Bleeding Gums
Epilepsy/Seizures
Mental Disorder
Wear Denture/Partial
Anxiety/Depression
Pain Med addiction
Autism/Aspergers

Are you ALLERGIC to any of the following?

Aspirin
Codeine
Latex
Local Anesthetics
Metals
Penicillin
Sulfa drugs
NONE OF THE ABOVE

- **Pre-Med Required? Yes/ No**
- **Surgeries in the last year? (If none put N/A)**

  _____

- **Are you on a blood thinner? Yes/ No**
- **Have you ever had a joint replacement? Yes/ No**
  - **If yes what year? _____**
- **Have you ever had heart problems or heart surgery? (If none put N/A)**
  - **If yes what year? _____**

Name of Physician

_____

Name of Orthopedist/Cardiologist

_____

Medications you are TAKING (if none put N/A)

_____

_____

_____

_____

Medications you're ALLERGIC to (if none put N/A)

_____

_____

_____

_____

The above information is correct to the best of my knowledge.

Patient Signature_____ **Date**_____

Parent/Guardian Signature (If under 18 years old) _____

OFFICE POLICY PROCEDURES

As of 2019, a new policy was created at our office that payments are due the day of service and the guardian signing the paper work for a minor is responsible for the account. As a service to our patients, we will file all insurance claims for services rendered in our office, however, we are not responsible for any fees not paid by your insurance company. When we provide you with an estimate of what is due, insurance is only estimated. It is the patient's responsibility to follow up with their insurance companies if more exact estimates are needed for the treatment. All balances are due within 90 days of treatment or a finance charge of 1.5% may be applied monthly. If your account is not paid in full and has to be turned over to a collection agency, there will be a $25 charge applied to that account.

In order to better serve our patients in a timely manner, we request a minimum of 24 hours' notice if you are unable to make an appointment.

If an insurance check is mailed to you, you must bring the original check along with the EOB to our office for services rendered.

I have been made aware of the office policies, insurance policies, and payment requirements of Gray Dental Associates and I agree to follow all guidelines.

Type name of patient

_____

Date

_____

Signature of patient/guardian

_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have the right to request the HIPAA policies and notice of practice policy from Gray Dental Associates.

I give Gray Dental Associates permission to discuss my dental records and account with the following people:

1._____

2._____

Sign _____ **Date** _____