GROVE AUSTIN
FAMILY DENTISTRY

Welcome!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. Please fill out this form as completely as possible. We want to make sure that we are well informed about your medical history, current medications and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

About You

Today's Date_____

How did you hear about us? _____

Name (First, Middle, Last): _____

I prefer to be addressed as:_____ Circle one: **M F**

Birth date: _____ Age: _____SS#_____

Address: _____

City: _____State: _____Zip: _____

Email Address: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____State: _____Zip: _____

Circle one: **Single Married Widowed Divorced Separated Partnered**

Spouse's Name: _____

Spouse's Birthday: _____SS#_____

Spouse's Employer: _____Occupation: _____

When and where are the best times to reach you?

_____

Other Family Members seen by us: _____

Dental Insurance

If you have dental insurance, please give us the info on page 3!

Emergency Contact

Name: _____Relationship: _____

Home Phone: _____Cell #_____

Does your emergency contact live with you? **Yes No**

Acknowledgements & Signatures

I acknowledge that the information I give in this form is correct to the best of my knowledge. This information will be held in the strictest confidence. I will inform the office of any change to my insurance or medical status.

Signature: _____

Date: _____

I understand that I will be required to pay my **estimated** portion of Dr. Viren Abreo's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursements.

Signature: _____

Date: _____

Grove Austin Family Dentistry
1500 W. 38th St. Ste 14
Austin, TX 78731
(512) 452-5713

Medical History

Do you have a physician? **Yes No** Physician's Name: _____Phone: _____

Date of Last Physical: _____ Current Physical Health: **Excellent Good Fair Poor Very Poor**

Are you currently under the care/supervision of a physician? **Yes No**

Please Explain: _____

Are you currently taking any prescription medications? **Yes No**

Please list all medications with correlating diagnosis: _____

_____

_____

For Women: Are you taking birth control pills? **Yes No** Are you pregnant? **Yes No** Are you nursing: **Yes No**

Do you or have you ever used tobacco in any form? **Yes No** If yes, how much? _____For how long? _____

Allergies: Circle any and all of the following to which you are allergic:

Aspirin Barbiturates/Sleeping Pills Codiene Dental Anesthetics Erythromycin Ibuprophen/Motrin Jewelry/Metals Latex Percocet Penicillin Tetracycline Vicodin

List any other Medications and /or Materials to which you think you might be allergic: _____

Medical Conditions:

Have you ever had any of the following Medical conditions? Circle Yes or No

Abnormal Bleeding	**Yes No**	Frequent Headaches	**Yes No**	Mitral Valve Prolapse	**Yes No**
Alcohol or Drug Abuse	**Yes No**	Glaucoma	**Yes No**	Osteoporosis	**Yes No**
Anemia	**Yes No**	Hay Fever	**Yes No**	Pacemaker	**Yes No**
Arthritis	**Yes No**	Heart Attack	**Yes No**	Psychiatric Problems	**Yes No**
Artificial Bones/Joints	**Yes No**	Heart Murmur	**Yes No**	Radiation Treatment	**Yes No**
Asthma	**Yes No**	Heart Surgery	**Yes No**	Rheumatic/Scarlet Fever	**Yes No**
Blood Transfusion	**Yes No**	Hemophilia	**Yes No**	Seizures	**Yes No**
Cancer/Chemotherapy	**Yes No**	Hepatitis	**Yes No**	Shingles	**Yes No**
Colitis	**Yes No**	Herpes/Fever Blisters	**Yes No**	Sickle Cell Disease	**Yes No**
Congenital Heart Disease	**Yes No**	High Blood Pressure	**Yes No**	Sinus Problems	**Yes No**
Diabetes	**Yes No**	HIV or AIDS	**Yes No**	Stroke	**Yes No**
Difficulty Breathing	**Yes No**	Hospitalized for any reason (If yes please explain below)			**Yes No**
Emphysema	**Yes No**	Kidney Problems	**Yes No**	Thyroid Problems	**Yes No**
Epilepsy	**Yes No**	Liver Disease	**Yes No**	Tuberculosis/TB	**Yes No**
Fainting Spells	**Yes No**	Low Blood Pressure	**Yes No**	Ulcers	**Yes No**

Please explain any serious medical conditions you have ever had: _____

_____

Why have you come to our office today? _____ Are you in pain? _____

Previous Dentist_____Phone:_____Last visit date: _____

What was done? _____ Date of Last Cleaning: _____Date of Last Dental X-Rays_____

Have you ever been told you require antibiotics before dental treatment? **Yes No**

Do you have or have you ever had any of the following conditions, ailments, or treatments? Circle Yes or No.

Bad Breath	**Yes No**	Food Collection Area	**Yes No**	Orthodontics	**Yes No**
Bleeding Gums	**Yes No**	Grinding Teeth	**Yes No**	Pain Around Ear	**Yes No**
Blisters on Lips or Mouth	**Yes No**	Gums Swollen	**Yes No**	Periodontal Treatment	**Yes No**
Broken Fillings	**Yes No**	Jaw Pain	**Yes No**	Sensitive to Cold	**Yes No**
Clenching of Teeth	**Yes No**	Jaw Fatigue	**Yes No**	Sensitive to Heat	**Yes No**
Jaw Clicking or Popping	**Yes No**	Lip or Cheek biting	**Yes No**	Sweet Sensitivity	**Yes No**
Dry Mouth	**Yes No**	Loose Teeth	**Yes No**	Sore in Mouth	**Yes No**

Have you ever had a serious /difficult problem associated with any previous dental work? **Yes No**

Do you ever experience pain in your jaw joint (TMJ/TMD)? **Yes No**

How would you classify your current dental health? **Excellent Good Fair Poor Very Poor**

On a scale of 1-10, how would you rate your smile? (10 being the best) _____

Would you like whiter teeth? **Yes No** Would you like fresher breath? **Yes No**

What else about your smile would you like to change?

_____

_____

Person responsible for your account other than yourself:

_____

_____

Dental Insurance Information:

Do you have Dental Insurance Coverage? **Yes No**

Dental Insurance Company Name: _____

Dental Insurance Company Address: _____

City: _____State: _____Zip: _____

Dental Insurance Company Phone #_____

Your Group #_____

Your Employee ID #_____

Insured's Name: _____ Relationship: _____

Insured's Birthday: _____ Social Security Number: _____

Alternate ID #_____

Insured's Employer: _____

Good Contact # of Insured _____

********Please tell us if you have a secondary dental insurance coverage.***

If possible, please bring your dental insurance card or insurance information for our records.

FINANCIAL POLICY

PAYMENTS

- We accept cash, checks, Visa, MasterCard, American Express, Discover and CareCredit.
- Full payment is due at the time of service for patients without a dental plan.
- Insurance deductibles and co-payments are due in full at the time of service.

PATIENTS WITH DENTAL INSURANCE

We ask that you provide us with all of your insurance information prior to your first appointment. Your dental plan may or may not include benefits for services rendered in this office. The benefits you receive are in accordance with your dental plan agreement, which is determined by either your employer or yourself.

Please understand your dental plan is a contract between you and your carrier. You, the patient, are responsible for all the services rendered and the balance of what your dental plan does not cover. We are happy to assist you in obtaining the allowable benefits and to process the required forms at no charge despite time necessary to do so. Claims uncollectible after 90 Days will become the responsibility of the patient and payable in full. If you have 2 insurance policies, a primary and a secondary, we will submit to the primary first and then to the secondary after we receive a statement from the primary insurance company.

COPAYMENTS

When we collect co-payments, we are estimating your amount due at the time of service. We try to estimate as close as possible in order for you not to make any additional payment. However, sometimes our estimates leave a balance, in which case we will be sending you a bill for the difference. It is not our intention to have you pay any more than you would owe.

MISSED APPOINTMENTS

We kindly ask for at least a 48-hour notice if cancelling or changing an appointment. Without at least a 48-hour notice for a cancellation or change of appointment, a $50 charge will be applied to your account. Help us serve you better by keeping your scheduled appointments. Please Note: If you are more than 15 minutes late for your appointment, we will need to reschedule. We require an adult to accompany all children under the age of 18.

FINANCIAL

- A monthly finance charge will be added for any account balance over 30 days old.
- Any expense incurred for returned checks will become your responsibility and will be added to your account balance.
- Any balance over 90 days will be due by patient and patient will wait for insurance reimbursement.

We encourage you to discuss any financial concerns that you may have so that we may assist you in the effective management of your account.

I have read, understand and agree to the financial policy described above.

_____ _____

Signature of Patient, Parent or Guardian Date

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.