Gole Dental Group Patient Information

Date:_____

Patient Name _____ **Preferred Name:** _____
Last First Middle Initial

(Please Circle) Female Male (Please Circle) Married Single Child Other

Personal

Age ____ SS# _____ Birth Date: _____ License or ID#: _____
(Month / Day / Year)

Address:_____
Street City State Zip

Phone Numbers

_____ _____ _____
Home # Work # and Extension Best Time To Call ?

_____ _____ _____
E-Mail Cell #/ Other # Emergency Contact # Name

Primary Insurance

Patient Name: _____
Subscriber: _____
Date of Birth of Subscriber: _____
Employer: _____
Carrier: _____
Subscriber SS#: _____
Insurance ID #: _____
Group #: _____
Relation to Subscriber:
Self Spouse Child Other

Secondary Insurance

Patient Name: _____
Subscriber: _____
Date of Birth of Subscriber: _____
Employer: _____
Carrier: _____
Subscriber SS#: _____
Insurance ID #: _____
Group #: _____
Relation to Subscriber:
Self Spouse Child Other

If Patient is a minor child, then please complete the following information:

Father's Name: _____
Birth Date: _____
Social Security #: _____
Address: _____
_____
Home Phone #: _____
Employer and #: _____
Cell #: _____

Mother's Name: _____
Birth Date: _____
Social Security #: _____
Address: _____
_____
Home Phone #: _____
Employer and #: _____
Cell #: _____

Name:

Financial Policy

We recognize the need for a definite understanding between patient and dentist regarding financial arrangements for dental care. Responding to this need, we have established the following financial policy. Please take a moment to read through the policy and sign it. If you have any questions regarding this policy, please do not hesitate to ask us.

We participate with a few dental plans. When we participate with a benefit plan, we agree to submit claims for the services rendered. The approved amount often includes a specific amount to be paid by the patient, co-pays and deductibles. Our dental office cannot render services on the assumption that the resulting charges will be covered by insurance. You are responsible for your deductible, your co-payment amounts and any services not covered by your insurance. We require these out-of-pocket expenses to be paid at the time of service. If this is not possible, rescheduling your appointment will be necessary.

Please remember that your insurance coverage is a contract between you, your employer and your insurance company. Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Out of courtesy to our patients, our office will help prepare the patient's insurance forms, assist in making collections from insurance companies, and will credit collections from insurance to the patient's account.

I understand that the fee estimates for dental care can only be extended for a period of six months from the date of consultation.

I have read and understood the above Financial Policy.

Signature of Patient (If under age 18, Parent or Guardian) _____ Date: _____

Assignment of Insurance Benefits

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my patient records.

I hereby assign all dental benefits to which I am entitled to Gole Dental Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature of Patient (If under age 18, Parent or Guardian) _____ Date: _____

Understanding Your Health Record and Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. We refer to this information as your dental record. Your dental information is personal. The Dentists' and staff at Gole Dental Group are committed to protecting your dental information. Understanding what is in your record and how your health information is used helps to ensure its accuracy.

Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, plans for future care, demographics, and health insurance information. We need this information to provide you with quality care and to comply with certain legal requirements. We use this information for planning your care and treatment, to obtain payment for treatment, and for administrative purposes to evaluate the quality of care you receive.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

How This Office May Use and Disclose Your Dental Information

We use and disclose health information about you for treatment, payment, and health care operations. For example, we may use or disclose your health information to other physicians or healthcare providers providing treatment to you. We may use and disclose your health information to obtain payment for services we provide to you. We may use and disclose in connection with our healthcare operations. The following describes the different ways that your dental information may be used or disclosed by our office for situations other than for treatment, payment, or administrative review. Not every possible use or disclosure is specifically mentioned.

Appointment Reminders: We may use and disclose information as a reminder to you that you have an appointment at this office. We currently use methods of phone calls, messages on answering machines, text messages, or postcards sent through the mail/e-mail.

As Required By Law: We will disclose dental information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose dental information to someone able to help prevent a serious threat to your health and safety or the health and safety of the public or another person.

Individual Rights

In most cases, you have the right to look at or obtain a copy of your health information. It is our policy to charge an initial fee of $21.95, and .25 cents for each page for copies of your dental record. If you request a copy of your dental record, or to review your dental record, we will respond to your request within 30 days of receipt of your notice. The fee is to be paid before the duplication of records.

You have the right to receive information on the instances where we have disclosed health information about you for reasons other than treatment, payment, or administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information except when specifically authorized by you, or when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact our office. You also may send a written complaint to the U.S. Department of Health and Human Services. Our office can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice and in our policies.

If you have any questions or complaints, please contact:

Office Manager
121 W. Woodlawn Ave.
Hastings, MI 49058
Phone: (269) 948-2244 Fax: (269) 948-2284
Email: smiles@goledentalgroup.com

Acknowledgement of Receipt

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy, "Understanding Your Health Record and Information" form, and a copy of our office's updated cancellation policy.

Signature of Patient (If under age 18, Parent or Guardian) _____ Date: _____

Documentation of Failure to Obtain Signed Acknowledgement

On _____, 20 ____, Gole Dental Group presented this Acknowledgement of Receipt of Notice of Privacy Form to _____ (the "Patient"). The patient refused to provide a signature when requested.

In an effort to protect your privacy, please indicate how we can release your dental information and to whom.

I give permission for my information to be released via:

Fax	Yes	No
Mail	Yes	No
Phone	Yes	No
Email/Text	Yes	No

I give permission for my dental information to be released to the following individuals:

Mother	Yes	No	_____
Father	Yes	No	_____
Grandparent(s)	Yes	No	_____
Other Physicians	Yes	No	_____
Legal Guardian	Yes	No	_____
Spouse	Yes	No	_____
Other	Yes	No	_____

Gole Dental Group
121 W Woodlawn Ave
Hastings Michigan 49058
(269) 948-2244

Patients Name: _____

What is the reason for your visit today? _____

Do you have any dental problems now? Yes No If yes, then please describe: _____

Previous Dentist's Name _____ City, State _____

Why did you leave your last Dentist? _____

Who referred you to our practice? _____

When was your Last dental visit? _____ **Last cleaning**? _____ **X-rays**? _____

How often do you do the following:

Brush? _____ Floss? _____ Use a Mouth rinse? _____ What Mouth rinse? _____

What kind of Toothbrush do you use? Manual Electric Both

Please circle other dental aids used: Flosser Toothpick Waterpik Tongue scraper Bridge Aid Other_____

Are your teeth sensitive to:

Hot Cold Sweets Biting Chewing? (please circle which)	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you get cold sores, blisters, or any other oral lesions?	Yes	No
Do your gums bleed or hurt while brushing or flossing?	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 get caught between your teeth?	Yes	No
If yes, then where? _____		

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
A bite splint or mouth guard?	Yes	No
A serious head or mouth injury?	Yes	No
If yes, please describe_____		
_____		
Do you have a partial, denture or dental implants?	Yes	No

Do you experience the following:

Clench or grind your teeth (while awake or asleep) ?	Yes	No
Dry mouth?	Yes	No
Hold objects with your teeth (ex: fingernails, pencils, etc.)?	Yes	No
Do you now (or in the past) use tobacco (smoke or chew)?	Yes	No
Snore or have any other sleeping disorder (ex: sleep apnea, use a CPAP)?	Yes	No

Have you experienced any of the following:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty opening or closing the mouth?	Yes	No
Difficulty chewing on either side?	Yes	No
Headaches, neck aches, backaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Please circle the following you have or do:

Cheek/Lip biting	Nail biting	Tongue thrust
Thumb sucking	Prolonged pacifier	Excessive alcohol
Drug abuse	Mouth breather	Gum chewer
Frequent Pop 3+/wk	Juice	Coffee
Tea	Sports drinks	Energy drinks
Sugared sweets	Frequent snacking	Beer
Wine	Liquor	Other not listed

How do you feel about your smile? _____

_____

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

If yes, then are you concerned about finances to restore your teeth? Yes No

Do you feel nervous about dental treatment? Yes No

If yes, what is your biggest concern? _____

Is there anything else about dental treatment that you would like us to know? _____

Patient Name:_____

Are you currently under the care of a Physician, Specialist, Chiropractor, or Other due to a specific reason? Yes No
If yes, then please explain which and why_____

Physician, Specialist, Chiropractor, or Other's Name _____**Phone #** ( )_____

Name _____**Phone #** ( )_____

Have you been hospitalized within the last 5 years due to a Surgery, Accident, Illness, or other Condition? Yes No
If yes, then please explain _____

Are you currently taking any Vitamins, Herbal supplements, or any Medication? (Include all Prescription, Over the counter, Aspirin) Yes No
If yes, then please list names and dosages:

_____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

Do you have any drug allergies (or adverse reaction) that you are aware of? Yes No

(Please circle all) Penicillin Amoxicillin Clindamycin Keflex Codeine Sulfa Bactrim Other

Have you ever taken prescription medications for weight loss (diet pills)? Yes No
If yes, then please circle Fen-Phen Pondimen Redux Other
If yes, then did you have a medical exam for heart issues? Yes No

Have you ever taken bone loss prevention drugs, such as Fosamax, Actonel, Boniva, or other similar drugs? Yes No

Please circle "Yes" or "No" to each item that you have had, or have at present.

AIDS/HIV Positive	Yes No	Fainting	Yes No	Mitral Valve Prolapse	Yes No
Allergies	Yes No	Fibromyalgia/Chronic Fatigue	Yes No	Nervous Disorders	Yes No
Arthritis/Rheumatism	Yes No	Food Allergies	Yes No	Neurological Disorders	Yes No
Artificial Heart Valve	Yes No	Glaucoma	Yes No	Pacemaker	Yes No
Artificial Joints (hip,knee,etc)	Yes No	Hay Fever	Yes No	Pregnancy	Yes No
Asthma	Yes No	Head Injuries	Yes No	Pre Med	Yes No
Blood Transfusion	Yes No	Headaches / Migraines	Yes No	Prosthetics	Yes No
Bruises Easily	Yes No	Heart Attack	Yes No	Psychological/Psychiatric Care	Yes No
Cancer	Yes No	Heart Disease	Yes No	Radiation Treatment	Yes No
Chemotherapy	Yes No	Heart Murmur	Yes No	Respiratory Problems	Yes No
Chest Pain	Yes No	Heart Surgery	Yes No	Restless Leg Syndrome	Yes No
Chronic Cough	Yes No	Hepatitis A B C (circle)	Yes No	Rheumatic Fever	Yes No
Congenital Heart Disease	Yes No	High Blood Pressure	Yes No	Sinus Problems	Yes No
Cortisone Medicine	Yes No	Hives	Yes No	STD(s)	Yes No
Coumadin/Warfarin	Yes No	Jaundice	Yes No	Stent(s)	Yes No
Diabetes (Type I II circle)	Yes No	Jaw Clicking	Yes No	Stroke	Yes No
Dizziness	Yes No	Kidney Disease	Yes No	Swollen Ankles	Yes No
Ear / Eye Problems	Yes No	Latex Sensitivity	Yes No	Thyroid Problems	Yes No
Emphysema	Yes No	Liver Disease	Yes No	Tuberculosis	Yes No
Epilepsy / Seizures	Yes No	Low Blood Pressure	Yes No	Tumors	Yes No
Excessive Bleeding	Yes No	Metal Sensitivities	Yes No	Ulcers	Yes No

Do you have any other disease, condition, or problem not listed? Yes No
If yes, then please list _____

Please circle if there are any of following in your family history: Cancer Stroke Heart disease Diabetes
Have you lost or gained more than 10 pounds in the last year? (please circle which one) Yes No

WOMEN ONLY: Are you pregnant or think you are pregnant? Yes No If yes, then how many months along? _____ months
Are you nursing? Yes No Do you use Birth control prescriptions? Yes No

I have answered all questions to the best of my knowledge. If further information is needed, then you have my permission to ask the respective health care provider/agency, who may release such information to you. I will inform the staff of any changes in my health or medication.

Mobile #:_____ **Email:**_____

Signature of Patient (If under 18 years old, then Parent/Guardian)_____**Date**_____

DDS / Hyg signature(s)_____ Date_____
Additional notes: