

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: _____

Mother's Name: _____

Birth Date: _____

Birth Date: _____

Social Security #: _____

Social Security #: _____

Address: _____

Address: _____

Home Phone #: _____

Home Phone #: _____

Employer and #: _____

Employer and #: _____

Cell #: _____

Cell #: _____

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.

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
Other	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:

Have you ever had:

Hot Cold Sweets Biting Chewing? (please circle which)	Yes No	Orthodontic treatment?	Yes No
Have you noticed any mouth odors or bad tastes?	Yes No	Oral surgery?	Yes No
Do you get cold sores, blisters, or any other oral lesions?	Yes No	Periodontal treatment?	Yes No
Do your gums bleed or hurt while brushing or flossing?	Yes No	A bite splint or mouth guard?	Yes No
Have your parents experienced gum disease or tooth loss?	Yes No	A serious head or mouth injury?	Yes No
Have you noticed any loose teeth or change in your bite?	Yes No	If yes, please describe _____	
Does food tend to get caught between your teeth?	Yes No	_____	
If yes, then where? _____		Do you have a partial, denture or dental implants?	Yes No

Do you experience the following:

Have you experienced any of the following:

Clench or grind your teeth (while awake or asleep)?	Yes No	Clicking or popping of the jaw?	Yes No
Dry mouth?	Yes No	Pain? (joint, ear, side of face)	Yes No
Hold objects with your teeth (ex: fingernails, pencils, etc.)?	Yes No	Difficulty opening or closing the mouth?	Yes No
Do you now (or in the past) use tobacco (smoke or chew)?	Yes No	Difficulty chewing on either side?	Yes No
Snore or have any other sleeping disorder (ex: sleep apnea, use a CPAP)?	Yes No	Headaches, neck aches, backaches or shoulder aches?	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? _____

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 Pondimin 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.

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

DDS / Hyg signature(s) _____ **Date** _____

Additional notes:

WELCOME TO OUR PRACTICE

We are looking forward to meeting you on your scheduled appointment date.

Day _____ Time _____

Enclosed you will find the new patient paperwork including medical and dental history forms to fill out and bring to our office the day of your visit.

If you are currently taking any vitamins, herbal supplements, or any medications (including all prescription, over the counter, and aspirin), please bring a list or the bottles themselves. Also, if you are allergic to any medications, then please bring that list.

In addition to helping you with your dental concerns, we also like to keep your dental costs down. To achieve this, we would appreciate payment at the time of service. If this causes any concern, please call our office to make prior arrangements. If you have a co-pay or deductible, then please be prepared to pay it on the day of your visit.

If you are unable to keep your appointment, then please give our office at least a 24 hour notice. If you are going to be more than 15 minutes late, then we will need to reschedule your appointment. Also, if you do not bring your completed paperwork with you, then your appointment may have to be rescheduled.

We look forward to seeing you,

The Staff at Gole Dental Group