GRAND AVENUE
DENTAL CENTER

New Patient Information

Patient Name: _____
Last *First* *Mi* *Preferred Name*

Gender: M F **Family Status:** Married Single Child

Personal Info: _____
Birth Date *Social Security #* *Email*

Contact Info: _____
Mobile Phone *Home Phone* *Work Phone*

Address: _____
Mailing Address *City* *State* *Zip*

Emergency Contact: _____
Last *First* *Phone* *Relation*

Responsible Party Information: *(Party responsible for patient, if other than patient)*

Name: _____
Last *First* *Mi* *Preferred Name*

Date of Birth: _____/_____/_____

Contact Info: _____
Mobile Phone *Work Phone* *Email*

Address: _____
Mailing Address *City* *State* *Zip*

Employer name: _____ **Phone**: _____

Employer Address: _____
Mailing Address *City* *State* *Zip*

Insurance Information

Please alert the front desk if you have an insurance card to put on file

Primary Insurance:

Insurance Co. Name: _____

Insurance Address: _____
Mailing Address *City* *State* *Zip* *Phone*

Name of Policy Holder (the insured): _____
Last *First* *Mi*

Policy Holder Address: _____
Mailing Address *City* *State* *Zip*

Policy Holder Date of Birth: ___/___/_____

Policy/Subscriber ID #: _____ **Group Name or Number:** _____

Relationship to Insured: Self Spouse Child

Secondary Insurance (if applicable):

Insurance Co. Name: _____

Insurance Address: _____
Mailing Address *City* *State* *Zip* *Phone*

Name of Policy Holder (the insured): _____
Last *First* *Mi*

Policy Holder Address: _____
Mailing Address *City* *State* *Zip*

Policy Holder Date of Birth: ____/____/____

Policy/Subscriber ID # _____ **Group Name or Number:** _____

Relationship to Insured: Self Spouse Child

Medical History

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? **Yes No**
Within the past year, have there been any changes in your general health? **Yes No**

What is the approximate date of your last medical exam? _____
Primary Care Physician's name, address, & phone number: _____

Have you ever had complications following dental treatment? **Yes No**
Are you currently under the care of a physician due to a specific condition? **Yes No**
Have you been hospitalized within the last 5 years due to a surgery or illness? **Yes No**
Do you use Tobacco (smoking or chewing)? **Yes No**
Do you require the use of corrective lenses (contacts or glasses)? **Yes No**

If any of the previous questions are marked yes, please explain: _____
_____

Have you ever had your sleep evaluated? **Yes No**
If yes, has as a physician recommended using a CPAP machine? **Yes No**
Do you snore loudly? **Yes No**
Do you often feel **tired**, **fatigued**, or **sleepy** during daytime? **Yes No**
Has anyone **observed** you stop breathing during your sleep? **Yes No**

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

Please list any medication name and dose/frequency taken. If you need additional space, please notify the front desk.

Medication: _____ Dose: _____ Frequency: _____ Medication Reason: _____
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Medication: _____ Dose: _____ Frequency: _____ Medication Reason: _____
Medication: _____ Dose: _____ Frequency: _____ Medication Reason: _____

Do you, or have you, had any of the following? Please Circle Y or N.

Heart Disease:	**Y**	**N**	**Stroke:**	**Y**	**N**	**Hepatitis:**	**Y**	**N**
High Blood Pressure:	**Y**	**N**	**Epilepsy:**	**Y**	**N**	**Tumors:**	**Y**	**N**
Heart Murmur:	**Y**	**N**	**Nervous Disorder:**	**Y**	**N**	**Radiation Treatment:**	**Y**	**N**
Congenital Heart Disease:	**Y**	**N**	**Mental/Behavioral Disorder:**	**Y**	**N**	**Dental Anxiety:**	**Y**	**N**
Artificial Heart Valve:	**Y**	**N**	**Anxiety**	**Y**	**N**	**Sensitive Gag Reflex:**	**Y**	**N**
Artificial Joints:	**Y**	**N**	**Depression**	**Y**	**N**	**Needle Phobia:**	**Y**	**N**
Arthritis:	**Y**	**N**	**Asthma:**	**Y**	**N**	**Pain Sensitivity:**	**Y**	**N**
Liver Disease:	**Y**	**N**	**Tuberculosis:**	**Y**	**N**	**Difficulty Numbing:**	**Y**	**N**
Kidney Disease:	**Y**	**N**	**Diabetes:**	**Y**	**N**	**Sleep Apnea:**	**Y**	**N**
Rheumatic Fever:	**Y**	**N**	**Blood Disease:**	**Y**	**N**	**Night-time acid reflux:**	**Y**	**N**
Scarlet Fever:	**Y**	**N**	**HIV Positive:**	**Y**	**N**	**Thyroid Disorder**	**Y**	**N**
Cholesterol:	**Y**	**N**	**STD:**	**Y**	**N**			

If you responded **Yes** to Mental/Behavioral Disorder, please explain. _____

Are you pregnant or trying to become pregnant? **Yes** **No** If pregnant, when is the due date?____/_____/_____

Do you have any allergies, to medications or otherwise? **Yes** **No** If yes, please list them: _____

Is there anything not listed that we should be aware of? **Yes** **No** If yes, Please list: _____
_____
_____

Dental History

What is the reason for your dental visit today? _____
When was your last visit to the dentist (if to a different office)? _____
What was done on your last dental visit (if to a different office)? _____
Prior Dentist's name, address, & phone number:_____

How frequently do you brush your teeth? **3+times/a day 2/day 1/day Weekly Seldom**
How frequently do you floss your teeth? **1+times/day 2 -6days/week 1 – 6 times/month Seldom Never**

Do your gums bleed when you brush or floss?	**Yes No**
Do your teeth experience sensitivity to cold or hot temperatures?	**Yes No**
Are any of your teeth currently causing you pain?	**Yes No**
Do you grind your teeth (either consciously or during sleep)?	**Yes No**
Are any of your teeth loose, or are you concerned about any teeth loosening?	**Yes No**
Do you currently have any dental implants, dentures, or partials?	**Yes No**

If any of the previous questions are marked "yes", please explain: _____
_____
If you could change anything about your mouth, teeth, or smile, what would it be? _____

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization
I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian: _____ Date _____

Relationship to Patient: _____

GRAND AVENUE
DENTAL CENTER

This notice describes your financial obligation and payment options

Fee for Service

Dr. Doser and her staff at Grand Avenue Dental Center work hard to give their patients the highest quality of care and customer service. In order to maintain this promise we will require fees to be paid at the time of service. For your convenience Grand Avenue Dental Center accepts cash, checks, and all major credit cards. Although we do not provide payment plans, we do offer the services of Care Credit. Qualified applicants of Care Credit have the options of 6- and 12-month 0% interest payment plans.

Insurance Policy

Your insurance policy is a contract between you and your insurer. Your accounts are still your responsibility. If we are not a provider for your dental insurance, you will be required to pay in full at the time of service. As a courtesy, Grand Avenue Dental Center will gladly file your insurance claim electronically on your behalf and your insurance will reimburse according to your contract. Please understand that we offer this service as a courtesy to our patients and we are not responsible for the benefits that your insurance company pays.

Grand Avenue Dental Center is a provider for **Delta Dental, Blue Cross Blue Shield,** and **Cigna**. We are also providers of **Equality Care of Wyoming** for patients 20 years old and under. With Delta Dental BCBS and Cigna you will be required to pay deductibles and co-pay amounts at the time of service. We will make every effort to estimate Insurance benefit amounts and the out of pocket expense you will be required to pay. ***However, these estimates are not a guarantee of benefits***. Once insurance has paid its portion, you are responsible for any remaining balance. Balances unpaid for 60 days may be subject to an interest fee of 1.5% each month until your bill is paid in full. If a balance is not paid after 90 days we may forward your account to a Collections Agency. You are responsible for any legal or collections related fees.

As Guarantor for this account, I understand that I am solely responsible for all of the fees for the dental treatment. I further agree that I have received a copy of this office financial policy and agree to its contents.

Signature:_____

Date:_____

Print Name: _____

GRAND AVENUE
DENTAL CENTER

Appointment Agreement

We make every effort to value your time and we schedule your appointment time just for you.

We truly appreciate your courtesy of giving us 48-hours notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.

We will not charge for your first missed appointment. However, after two missed appointments or short notice rescheduling in a 12 month span, you may be required to make a deposit when scheduling the next appointment. If you keep the appointment the deposit will be applied towards treatment. However, if you fail to keep the appointment the deposit will be forfeited. If we determine a continual pattern of missed appointments, you and your family members may be dismissed from our practice.

Appointments scheduled longer than one hour may require a base deposit of $50.00, with an added $50.00 per additional hour. This deposit will be applied towards treatment, unless the appointment is failed in which case the deposit will be forfeit.

It is our philosophy to continue to put our patients first and to make your experience a positive one. Please let us know if you have any questions.

Appointment Agreement:

- ___ **I acknowledge an appointment is a reservation.**
- ___ **I agree to provide a minimum of 48 hours notice if I need to change my appointment for any reason.**
- ___ **If I change 2 appointments without the required 48 hour notice in a 12 month span, I acknowledge I may be asked for a deposit at the time of scheduling in order to be appointed.**
- ___ **I understand appointments lasting longer than 1.5 hours may require a deposit.**
- ___ **We ask that you confirm your appointments either by returning our call or through solution reach. If we are unable to confirm your appointment or reach a valid telephone number, your appointment may be given to another patient.**

Patient Signature:_____ **Date:**_____

Print Name:_____

Jennifer Doser, D.M.D., P.C. I Tanner Moir D.D.S
303 S. 8th Street, Laramie, WY, 82070
Tom Doser, Office Manager, (307) 742-0722

Acknowledgement of Receipt of Notice

I, _____(print name) hereby acknowledge that I received a copy of this dental practice's Notice of Privacy Practices.
Yes No (circle one)
I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____

Signed: _____ Date: _____

If not signed by the patient, please indicate your relationship to the patient:
- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient: _____

Authorization

As required by the Health Insurance Portability and Accountability Act of 1996 Grand Avenue Dental Center may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize the use and disclosure of the following health information that pertains to me, Personal information, Medical History, Dental records, for the purposes outlined in the Notice of Privacy Practices

- I authorize Jennifer Doser, D.M.D., P.C. and her staff to make these disclosures of my health information
- I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.
- I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to 303 South 8th Street, Laramie, WY, 82070. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.
- I understand that this authorization will automatically expire when the revocation section is signed.
- I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not. If this document is not signed, Jennifer Doser, D.M.D., P.C. will not be able to file and collect insurance claims and therefore you will be required to pay for services in full at the time of service. Additionally, Jennifer Doser, D.M.D., P.C. will not be able to forward x-rays or other dental records to any other dental provider who may be providing you treatment.
- I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____
Signature Date

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____
Signature Date