GROVE CITY DENTAL

4079 Gantz Rd. Ste. A Grove City, OH 43123 614-801-1000 www.GroveCityDental.com

Name:_____ **Nickname:** _____ **Birth Date:**_____ **Age:**_____
Last First

Address: _____
Street Apt # City State Zip

Gender: ❍ M ❍ F **Status:** ❍ Married ❍ Single ❍ Other **Social Security:** _____

Cell Phone: _____ **Email Address:**_____
Home Phone: _____ **Occupation:** _____
Work Phone:_____ **Employer:**_____
Preferred Contact ❍ **Cell** ❍ **Text** ❍ **Email**

RESPONSIBLE PARTY INFORMATION:

Info is the same as above ◯

Name: _____ **Birth Date:** _____
Last First M.

Relationship to Patient: ❍ Patient ❍ Spouse ❍ Parent ❍ Legal Guardian
Gender: ❍ M ❍ F **Status:** ❍ Married ❍ Single ❍ Other **Social Security:** _____
Address: _____
If Different Than Above Street Apt # City State Zip
Cell Phone: _____ **Email Address:**_____
Home Phone: _____ **Occupation:** _____
Work Phone:_____ **Employer:**_____
Preferred Contact ❍ **Cell** ❍ **Text** ❍ **Email**

INSURANCE INFORMATION:

PRIMARY INSURANCE:
Name of Insured: _____ **Is Insured a Patient:** ❍ **YES** ❍ **NO**
Insured Date of Birth:_____ **Relationship to Patient:** _____
Company Name: _____ **Group:**_____ **I.D. #**_____
Insured Address: (if different)

SECONDARY INSURANCE:
Name of Insured: _____ **Is Insured a Patient:** ❍ **YES** ❍ **NO**
Insured Date of Birth:_____ **Relationship to Patient:** _____
Company Name: _____ **Group:**_____ **I.D. #**_____
Insured Address: (if different)

REFERRAL INFORMATION:

Whom may we thank for referring you to our practice? Please give their name so we can thank them!

- ❍ **Patient Referral:**_____
- ❍ **Team Member Referral:**_____
- ❍ **Radio**
- ❍ **Television**
- ❍ **Website**
- ❍ **Grove City Dental Sign**
- ❍ **Facebook**
- ❍ **Postcard**
- ❍ **Newsletter**
- ❍ **Newspaper**
- ❍ **Letter**
- ❍ **Other:**_____

Health History

Height:_____ **Weight:**_____ **Last Medical Exam Date:** _____

Medications: List any medications you are currently taking, including vitamins, herbs, OTC, birth control…ect:

(Front Desk Team Will Copy a List if You Carry One)

RX: _____ Dose: _____ How Often: _____ RX: _____ Dose: _____ How Often: _____

RX: _____ Dose: _____ How Often: _____ RX: _____ Dose: _____ How Often: _____

RX: _____ Dose: _____ How Often: _____ RX: _____ Dose: _____ How Often: _____

Any Allergies or Reactions to the following Medications?

Aspirin:	❍ **YES**	❍ **NO**	**Codeine:**	❍ **YES**	❍ **NO**
Penicillin:	❍ **YES**	❍ **NO**	**Erythromycin:**	❍ **YES**	❍ **NO**
Local Anesthetic:	❍ **YES**	❍ **NO**	**Nitrous Oxide:**	❍ **YES**	❍ **NO**

Others? (Please Describe):_____

Food Allergies? (Please Describe): _____

Are you in good health? ❍ **YES** ❍ **NO**

Any health changes in the past year? ❍ **YES** ❍ **NO**

Are you under the care of a physician? ❍ **YES** ❍ **NO**

If yes, for what condition(s)?:_____

Physicians Name: _____ **Specialty:**_____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? ❍ **YES** ❍ **NO**

If yes for what condition(s)?:_____

Do you Smoke? ❍ **YES** ❍ **NO** If yes, # of packs per day:_____ For how many years?_____

Do you Chew/Dip? ❍ **YES** ❍ **NO** If yes, where is your favorite spot? _____

Do you have history of alcohol and/or drug abuse? ❍ **YES** ❍ **NO**

If yes, please explain:_____

Are you using recreational drugs?

If yes, please explain:_____

Has your physician ever told you to take antibiotic prior to your dental visits? ❍ **YES** ❍ **NO**

Have you ever had complications following dental treatment? ❍ **YES** ❍ **NO**

RISK FACTORS

Infrequent Dental Visits	❍ **YES**	❍ **NO**	Wait Until Teeth Hurt/Break For Appt.	❍ **YES**	❍ **NO**
Brush < 2X Daily < 2 Mins	❍ **YES**	❍ **NO**	Clench or Grind Your Teeth	❍ **YES**	❍ **NO**
Do You Avoid Flossing	❍ **YES**	❍ **NO**	Crowded Teeth	❍ **YES**	❍ **NO**
Heavy Stain	❍ **YES**	❍ **NO**	Mouth Breather	❍ **YES**	❍ **NO**
Love Sweets	❍ **YES**	❍ **NO**	Tobacco Habits	❍ **YES**	❍ **NO**
Drink Pop, Energy or Sports Drinks	❍ **YES**	❍ **NO**	Well Water	❍ **YES**	❍ **NO**

WOMEN

Are you currently pregnant? ❍ **YES** ❍ **NO** If yes, what is your due date?_____

Any possibility you could be pregnant? ❍ **YES** ❍ **NO**

Are you currently nursing? ❍ **YES** ❍ **NO**

Do you have, or have you had any of the following diseases or problems? Check all that apply:

Anemia	❍ YES	❍ NO	Jaundice	❍ YES	❍ NO
Angina	❍ YES	❍ NO	Kidney Trouble	❍ YES	❍ NO
Arthritis	❍ YES	❍ NO	Liver Disease	❍ YES	❍ NO
Artificial Heart/ Valve	❍ YES	❍ NO	Low Blood Pressure	❍ YES	❍ NO
Artificial Joint or Grafts	❍ YES	❍ NO	Neck/ Back Problems	❍ YES	❍ NO
Asthma	❍ YES	❍ NO	Pacemaker	❍ YES	❍ NO
Bleeding Disorders	❍ YES	❍ NO	Painful Joints	❍ YES	❍ NO
Bronchitis	❍ YES	❍ NO	Persistent Diarrhea	❍ YES	❍ NO
Cancer	❍ YES	❍ NO	Pneumonia	❍ YES	❍ NO
Chronic Cough	❍ YES	❍ NO	Psychiatric Problems	❍ YES	❍ NO
Chronic Heartburn	❍ YES	❍ NO	Radiation Therapy	❍ YES	❍ NO
Compromised Immune System	❍ YES	❍ NO	Recent Weight Loss	❍ YES	❍ NO
Congenital Heart Defect	❍ YES	❍ NO	Respiratory Problems	❍ YES	❍ NO
Coronary Disease	❍ YES	❍ NO	Rheumatic Heart Disease	❍ YES	❍ NO
Diabetes / A1c # _____	❍ YES	❍ NO	Rheumatism	❍ YES	❍ NO
Emphysema	❍ YES	❍ NO	Seizures (1st_____ Last_____ Freq_____)	❍ YES	❍ NO
Fainting Spells	❍ YES	❍ NO	Severe "gag" reflex	❍ YES	❍ NO
Frequent Urination	❍ YES	❍ NO	Sinus Problems	❍ YES	❍ NO
Gastric Reflux	❍ YES	❍ NO	Sleep Apnea	❍ YES	❍ NO
Glaucoma	❍ YES	❍ NO	Stroke	❍ YES	❍ NO
Hay Fever/Allergies	❍ YES	❍ NO	Swollen Glands	❍ YES	❍ NO
Heart Attack	❍ YES	❍ NO	Thyroid Problems	❍ YES	❍ NO
Heart Murmur	❍ YES	❍ NO	TMJ Disorder	❍ YES	❍ NO
Hepatitis	❍ YES	❍ NO	Tuberculosis	❍ YES	❍ NO
High Blood Pressure ___ /___	❍ YES	❍ NO	Ulcers	❍ YES	❍ NO
HIV/AIDS	❍ YES	❍ NO	Untreated Sexually Transmitted Disease	❍ YES	❍ NO

Details?_____

_____

Are you taking Bisphosphonates (e.g.) Fosamax, Boniva, Aredia, Reclast, Zometa ❍ YES ❍ NO

Have you ever taken Bisphosphonates? ❍ YES ❍ NO

If yes, when did you stop taking them?_____

I understand that withholding any information about my health could seriously jeopardize my safety and care with Grove City Dental. I have reviewed this health history form carefully and have answered all questions truthfully and to the best of my knowledge. I will notify the staff of any conditions that are not listed on this medical form and any changes in my medical health at each visit.

Signature of Patient or Legally Authorized Representative **Date**

Printed Name of Patient or Representative **Date**

Dental History

We're Glad You've Found Us! Welcome To Our Family.

Please answer the following questions so that we have a better understanding of your dental concerns and expectations. This will help us ensure that your experience here is as beneficial to you as possible. Thank you!

1. Does dental treatment make you nervous? ❍ Not at all ❍ A little ❍ A lot

2. The following best describes my attitude toward dental health:

- ❍ I have done what was recommended for my dental health.
- ❍ I have not always done what dentists have recommended to me.
- ❍ I rarely go to the dentist and don't have much interest in dental work.

3. If you need treatment, your wishes would best be described as:

- ❍ Wanting the best restoration possible that will last the longest.
- ❍ Wanting the least expensive restoration that will get me by for now.

4. Do you have, or have you ever had any of the following?

Sensitivity to cold	❍ **YES**	❍ **NO**	Headaches	❍ **YES**	❍ **NO**
Sensitivity when chewing	❍ **YES**	❍ **NO**	Click or popping of the jaw	❍ **YES**	❍ **NO**
Sensitivity to hot	❍ **YES**	❍ **NO**	Shift or change in bite	❍ **YES**	❍ **NO**
Sensitivity to sweet	❍ **YES**	❍ **NO**	Difficulty opening/closing	❍ **YES**	❍ **NO**
Loose teeth	❍ **YES**	❍ **NO**	Clenching and grinding teeth	❍ **YES**	❍ **NO**
Unpleasant taste or bad breath	❍ **YES**	❍ **NO**	Do you wear a CPAP machine	❍ **YES**	❍ **NO**
Irritated or tender gums	❍ **YES**	❍ **NO**	Dentures	❍ **YES**	❍ **NO**
Bleeding gums	❍ **YES**	❍ **NO**	Dental implants	❍ **YES**	❍ **NO**
Gum Treatment	❍ **YES**	❍ **NO**	Braces	❍ **YES**	❍ **NO**
Do you floss daily	❍ **YES**	❍ **NO**	Do you have a regular dentist	❍ **YES**	❍ **NO**
			Last Visit: _____		

5. Do you consider your existing fillings or dental work to be unattractive? ❍ **YES** ❍ **NO**

If yes, please explain:_____

We Offer a Wide Variety Of Services!

Please put a check mark next to the services you would like more information about.

- ❍ Sedation Dentistry
- ❍ Cosmetic Options
- ❍ Whitening Options
- ❍ Invisible Braces / 6 Month Smile
- ❍ Veneers
- ❍ Snap On Smile
- ❍ Missing Teeth Options
- ❍ Dental Implants
- ❍ Dentures/Partials
- ❍ Bridges
- ❍ Same Day Crowns
- ❍ Sleep Apnea
- ❍ Bite Appliances
- ❍ Home Care Products

6. Do you have any other concerns? What brought you in today? How can we help?

Consent For Services

Grove City Dental - Dr. Scott D. Schumann D.D.S.

Welcome to Grove City Dental! We are excited that you have chosen our office to help you achieve great oral health. We appreciate the trust you have placed in us, and we will do our best to provide the high quality dental care that you expect and deserve. We believe that you should receive prompt attention and excellent service. We believe a satisfied patient returns for additional services and refers others to the office that can also benefit from our great care.

By signing, you hereby authorize the doctors and/or assignees to take radiographs, study models, photographs, or any other needed diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of you dental needs. Additionally you give permission for such items to be used for purposes of research, education, marketing or publication in professional journals. In addition, unless you notify our office otherwise, we may use your written comments in material to promote Grove City Dental and/or the team.

By signing you hereby authorize the Doctor and/or assignees to perform any and all forms of treatment, medication and therapy that may be indicated. By signing, you also indicate your understanding that the use of anesthetic agents embodies a certain risk.

By signing, you hereby authorize Grove City Dental to release your information to third party payers about your treatment, and to other health practitioners involved in your care.

By signing you hereby agree to assign all insurance benefits to Grove City Dental and/or the Doctor.

By signing, you hereby grant your permission to Grove City Dental and the Doctors or their assignees to contact you at home or work to discuss matters related to your care.

I have read and understand the above conditions and agree to their content.

Signature of Patient or Legally Authorized Representative **Date**

Printed Name of Patient Or Legally Authorized Representative **Date**

Emergency Contact Information

In the event of an emergency, whom should we contact?

Contact 1:

Name Relationship Phone

Contact 2:

Name Relationship Phone

Financial Policy

Thank you for choosing us to provide your dental care. We place a high priority on the dental health of our patients and our goal is for you to enjoy the benefits of a comfortable, functional and attractive smile. We've found that a clear understanding of our financial policy in advance of your dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

Patients with insurance:

It's important to remember that your insurance coverage is a contract between you and your insurance company. Benefits and coverage vary significantly from plan to plan. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to assist you with your investment in dental care. **The cost of treatment is your responsibility regardless of your insurance coverage.**

As a courtesy to our patients, we are happy to submit claims to your insurance company. In order to do this, you must provide us with accurate and up-to-date insurance information. We will verify your coverage before treatment and we will **estimate** the portion insurance will cover and your co-payment, including deductibles. This co-payment is due prior to or on the day of treatment unless other arrangements have been made ahead of time. This amount will be an **estimate** only, so there may be an additional balance due after payment from your insurance company. **You are responsible for any such remaining balance.**

For your convenience, we accept cash, checks, Visa, MasterCard, Discover and American Express.

Patients Without Insurance:

Payment is expected at the time of service unless prior arrangements have been made. As noted above, we accept cash, check, Visa, MC, Discover and American Express. We also accept Care Credit, which is an outside healthcare financing program that has several payment options upon approval. Another convenient alternative is provided through Compassionate Finance. A minimum of 50% of the provided treatment will be due on the day of service and the remainder will be broken into monthly payments. All options are dependent on treatment.

Returned Check Fees:

The fee for a returned check is $35.00 per occurrence. You will not be allowed to write another check until the full amount of the original check, plus the $35.00 fee are paid in full. Another incident may result in losing the privilege to pay by check at our office.

Minor Patients:

If you have a child under 18, please plan to be present at his or her appointment. If you are unable to attend, please call our office prior to the visit to take care of any necessary financial arrangements. In the case of divorced parents, please remember that the **parent bringing the minor child is responsible for payment of the child's treatment, regardless of any custodial decrees.**

Missed Appointments:

We understand that sometimes it is necessary to change your appointment. If you need to reschedule an appointment, please give us at least 2 business days advance notice. Missed appointments are costly for us and may prevent us from assisting another guest. Please be aware that failed appointments, or those cancelled with less than 2 business days notice, may incur a $50.00 missed appt fee or $75.00 per half hour for sedation visits.

I have read and understand the above conditions and agree to their content.

Signature of Patient of Legally Authorized Representative **Date**

Printed Name of Patient or Representative **Date**

PROFESSIONAL DENTAL ALLIANCE ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Grove City Dental - Dr. Scott D. Schumann D.D.S.

I have been given a copy of Grove City Dental's, a Professional Dental Alliance practice, Notice of Information and Privacy Practices, which describes how my health information is used and shared. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer at (765) 698-2492, or by visiting the Practice's web.

You may refuse to sign this acknowledgment form.

My signature below acknowledges that I have been provided with a copy of the Notice of Information and Privacy Practices:

Signature of Patient or Personal Representative **Date**

Printed Name of Patient or Representative **Title (Self, Guardian, Health Care Power Of Attorney)**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ **Individual refused to sign**
- ○ **Communication barriers prevented us from receiving acknowledgment**
- ○ **An emergency situation prevented us from receiving acknowledgment**
- ○ **Other (Please specify):_____**

_____ _____

Print Name Of Practice Employee Providing / Collecting Notice **Date**