Grogan's Mill Dental

25210 Grogans Mill Rd., Suite A
The Woodlands, TX 77380
(281)298-5225

Patient Information (Confidential) Today's Date_____

Preferred Name_____ Date of Birth_____ SS#_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer_____ Email Address_____

Business Address _____ City _____ State_____ Zip_____

Spouse/Parent's Name_____ Work phone_____

If Student, Name of School/College_____ City_____ State_____ ☐Fulltime ☐Part Time

Emergency Contact_____ Relationship_____ Phone_____

Whom Shall We Thank For Your Referral_____

Responsible Party

Name of Person Responsible for This Account_____

Relationship to patient_____ Address_____ Phone_____

Employer_____ Phone _____ Date of Birth_____

Driver's License #_____ SS#_____

Insurance Information

Name of Insured_____ Relationship to Patient_____

Date of Birth_____ SS#_____ Phone_____

Insurance Co._____ Group#_____ Phone _____

Employer_____ Phone _____

Smile Analysis **Ask Dr. Kathy how you can transform your smile!**

	Yes	No		Yes	No
Do you feel that your teeth are too small or too larger?	☐	☐	Are there spaces between your teeth?	☐	☐
Have your gums receeded?	☐	☐	Do your teeth slant one way or another?	☐	☐
Do you show too much gum tissue when you smile?	☐	☐	Are your teeth dull, dark, or stained?	☐	☐
Are you unhappy with any crowns in your mouth?	☐	☐	Are any of your teeth missing?	☐	☐
Are your teeth crooked, misshapen, or out of line?	☐	☐	Do any of your teeth have old fillings		
Are the biting edges of your teeth worn down?	☐	☐	stained blue or gray?	☐	☐

Patient Medical History

Physician_____ Office Phone_____

Are you r currently under any medical treatment? If yes, please explain_____

_____

Have you been hospitalized for any surgery or illness in the past 5 years? If yes, explain_____

_____

Are you currently taking any medications, including over the counter medications or supplements?
Please list all_____

_____

Do you use tobacco products? ☐ Smoke- cigarettes/pipe/cigar ☐Smokeless-dip/spit/chew/snus/snuff
If yes, how many years have you used tobacco products? _____ Amount per day_____

Do you have or have had any of the following? Please check all that apply.

☐Asthma	☐AIDS or HIV	☐Angina	☐Anemia
☐Artificial Heart Valve	☐Cardiac Pacemaker	☐Cancer	☐Cold Sores
☐Diabetes	☐Epilepsy	☐Emphysema	☐Fainting/Seizures
☐Glaucoma	☐High Blood Pressure	☐Heart Murmur	☐Heart Disease/Heart Attack
☐Hepatitis/ Jaundice	☐Joint Replacements	☐Joint Implant	☐Kidney Disease
☐ Latex Allergy	☐Liver Disease	☐Low Blood Pressure	☐Leukemia
☐Mitral Valve Prolapse	☐Respiratory Problems	☐Rheumatic Fever	☐Psychological Disorders
☐Radiation Therapy	☐Recent weight loss	☐Recent weight gain	☐Stroke
☐Stomach trouble	☐Stomach Ulcers	☐Sexually Transmitted Diseases	
☐Tuberculosis	☐Thyroid Problems	☐Nursing For Women	☐Pregnant: Due date_____

Other Conditions_____
Please list any ALLERGIES to medication_____

Patient Dental History

Name of Previous Dentist and Location_____ Date of last Exam_____

	Yes	No		Yes	No
Do your gums bleed while brushing of flossing?	☐	☐	Do you have frequent headaches?	☐	☐
Are your teeth sensitive to hot or cold liquids/food	☐	☐	Do you clench or grind your teeth?	☐	☐
Are your teeth sensitive to sweet or sour liquids/food	☐	☐	Do you bite your lips or cheeks often	☐	☐
Do you feel pain in any or your teeth?	☐	☐	Have you ever had any difficult extractions or		
Any sores of lumps in or near your mouth?	☐	☐	prolonged bleeding from it in the past?	☐	☐
Have you had any head neck or jaw injuries?	☐	☐	Have you had any orthodontic treatment	☐	☐
Have you ever experience any clicking or pain in TMJ			Do you wear dentures or partials?	☐	☐
area, difficulty in opening or closing your mouth?	☐	☐	Do you wear a night guard?	☐	☐

Our office understands dental visits tend to create various degrees of anxiety, how would you consider your level of anxiety? On a scale of 1-10 (10 being the highest), please rate yourself._____ Explain_____

_____

Reason for todays Dental visit_____

Signature or Patient/parent of minor _____Date_____

I have read and understood the above information. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If I have any changes in my health I will inform Dr. Shao and staff at my next appointment

Acknowledgment of Receipt of Notice of Privacy Practices and HIPPA Communication Consent Form

Patient Name:	Date of Birth:

This consent form allows the Organization to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

This Organization has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at the Organization.

_____ I hereby authorize that the Organization may leave messages on my voicemail to confirm
Initial appointments, and/ or may speak with other members of my household and leave messages with them regarding my appointments.

_____ I hereby authorize that the organization may disclose my health information to any person(s)
Initial who accompany me to my appointment, and are present with me in the office while I meet with the dentist and staff.

_____ I hereby authorize that the Organization may disclose my personal health information to the
Initial person who I have listed as my emergency contact.

_____ I hereby authorize that the Organization may disclose my personal health information to the
Initial following person (s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing but that the Organization services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that the Organization may refuse service if I revoke this consent.

I understand that I have the right to request- now and in the future- how protected health information is used or disclosed to carry out treatment, payment, and health care operations, and must be provided by me writing. I understand that while the Organization is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.
Signature of Patient_____ Date:_____

Signature of Parent (if minor)_____ Date:_____

Grogan's Mill Dental
General Dentistry
25210 Grogan's Mill Rd., Ste. A
The Woodlands, TX 77380
Telephone: (281)298-5225

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change you appointment, please give us a call at least 48 hours' notice.

There will be a charge of $75 per each hour scheduled for NO SHOW appointments rescheduling, or appointment cancellations within 48 hours of your appointment time. A NO SHOW appointment is not giving our office notice of you not coming to a scheduled appointment. Repeated cancellation or NO SHOW appointments will result in loss of future appointment privileges. This covers the cost of the staff members who are paid by the hour and the cost of chair time that has been especially reserved for you. Late notice changes in our appointment does not allow for sufficient time to refill your spot.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your treatment. Except for emergency treatment for another patient, you can expect our office to be prompt. We, of course, would appreciate the same courtesy from you.

Adding Collection Fee's to Account Balances
Agreement to Pay: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fee and/or court costs if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Texas and any other state.

Consent to Contact Debtors On Their Cell Phones
Express Prior Consent to Contact Consumer by Cell Phone: you agree, in order for us to service your account or to collect monies you may owe, (Grogan's Mill Dental) and/or agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded /artificial voice messages and/or use of automatic dialing device as applicable.

We have read this disclosure and agree that Grogan's Mill Dental, its employees and/or agents may contact me/us as described above.

_____ _____

Signature **Date**

Grogan's Mill Dental
25210 Grogan's Mill Rd. Suite A
The Woodlands, Texas 77380
(281)298-5225

Financial Guidelines

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. Therefore we are pleased to offer several payment options. Please read the following carefully. Our financial coordinator will answer any questions you may have, and assist you in selecting the appropriate financial plan for your needs.

For your convenience, we offer the following financial options:

1.In addition to personal checks and cash, we also accept payment through MasterCard/Visa, and American Express.

2.Care Credit

3.Dental Insurance

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract. However, please keep the following in mind:

-You insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage, and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions, and waiting periods.

-Our office policy states that you are totally responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result I our billing you directly for the remaining balance.

-We are committed to providing the highest quality care. Our treatment recommendations and the dental services we provide are in the best interest of the patient's health. The patient is responsible for payment in full regardless of an insurance company's arbitrary determination of treatment necessity.

–Our participation in a Preferred Provider Organization (PPO) is a contract between this office and the organization to provide dental services for the negotiated network fee schedule. Individual coverage and benefits will vary within the organization and are dependent on the contract between you, your employer, and the insurance company. While we guarantee our fees will not exceed the network fee schedule, we cannot be responsible for variances in coverage and benefits within the PPO.

-If your coverage changes for any reason, please notify the office immediately.

By signing this form, you have ready and understand our policy. Any denials or insurance payments less than estimated will be our responsibility. Payment will be due upon our billing cycle. All estimated out of pocked fees and deductible are due the day of treatment. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy.

Usual and Customary Fees

Our practice is committed to providing the best treatment for our patient, and we charge what is usual and customary for our area and experience. You are responsible for payment regardless of any insurance company's arbitrary determination for usual and customary fees.

I have read the Financial Policy. I Understand and agree to this Policy

Signature of Patient/Parent of Minor_____ Date_____