WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ M ☐ F ☐ Non-binary

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Cell #: (____) _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Contact #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Contact #: (____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you (for emergency).

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

Address: _____

_____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol / Drug Abuse	Y	N	Herpes / Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+ / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Autism	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer /Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Osteoporosis / Paget's Disease
Y	N	Covid-19	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Treatment
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic / Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Have you received vaccination for Covid-19? ☐ Yes ☐ No

Type? _____ Date(s)? _____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin
Y	N	Codeine	Y	N	Latex
Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Tetracycline			
Y	N	Other			

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

Gramercy Smiles

A Holistic Approach to Dentistry

PART A

ASSIGNMENT OF FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

1. I authorize the release of any dental benefit information necessary to process my Insurance claim(s).
2. I authorize and request payment of dental benefits directly to GRAMERCY SMILES
3. I agree that this authorization will cover all or partial dental services rendered
4. I understand I am financially responsible for any charges whether or not paid by the insurance plan and further agree to pay GRAMERCY SMILES for any and all patient responsible balances,co-payments,deductibles and non covered services indicated by my insurance policy
5. I agree that a photocopy of this form may be used in a lieu of the original.

Patient/representative signature	Print Name	Date

PART B

PAYMENT IS REQUIRED AT THE TIME OF YOUR VISIT!!

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy to offer the following options:

Payment by Cash **Payment by Credit Card**

Please circle your choice, sign below and return to the receptionist before treatment. Our office is enrolled in the Care Credit Program, as well as the Chase Health Advantage Program. These programs provide financing for dental treatment above $300. Please speak to the Office Manager if you are interested in applying for either of these plans. *PLEASE NOTE: GRAMERCY SMILES IS NOT RESPONSIBLE FOR OR LIABLE IN ANY WAY WITH RESPECT TO ANY ARRANGEMENT BETWEEN YOU AND A THIRD PARTY FINANCING COMPANY.*

If none of the above applies, please see the Office Manager. Thank you.

Patient/representative signature	Print Name	Date

Gramercy Smiles

A Holistic Approach to Dentistry

RESERVED APPOINTMENT FEE

Dear Patient,

An appointment time is reserved specially for you. This convenient appointment system helps our office run smoothly for both patients and staff. We schedule an appropriate amount of time for the procedure our patients need, and we take pride in staying on schedule and preventing unnecessary waiting time. We respect YOUR time and ask that you show us that same respect.

When making an appointment, please be sure that other obligations allow you adequate time to arrive promptly for your dental visit. Your cooperation allows us to be on time for your appointment, and our other patients.

If you know that you are going to be 10 minutes late, please call before you come. That way, if it becomes necessary to reschedule your appointment, you will have avoided a hurried late trip to the office and mutually embarrassing situation at the business desk.

If you find you are unable to keep a scheduled appointment, please call IN ADVANCE so that we may reschedule you at a convenience time, and enable us to fill this cancellation with another patient.

There will be NO charge if we are given 48 hours notice.

Should you fail to contact us, there is a MINIMUM charge of $250.00 per visit for the missed appointment time.

If you are a family of 2 or 3 scheduled at the same time and find that one of them is not able to come, please try to keep the other appointments to avoid multiple charges for missed appointments.

Thank you for your cooperation, courtesy, and understanding.

Sincerely,
Gramercy Smiles Staff

_____
Print Name

_____
Signature and Date

Gramercy Smiles

A Holistic Approach to Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

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

- _____ Individual refused to sign
- _____ Communication barriers prohibited obtaining the acknowledgement
- _____ An emergency situation prevented us from obtaining acknowledgement
- _____ Other (Please specify)

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose you health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENTS RIGHTS

Access: You may have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $35 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of the Notice for a full explanation of our fee structure.)

Disclosure Accountings: You have the right to receive a list of instances in which we or our business associated disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activates, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing. And it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or the have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed a the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Pharmacy Information

First Name: _____ Last Name: _____

Pharmacy Name: _____

Pharmacy Tel# _____

Pharmacy Address: _____

_____

_____

Allergy to medication: _____

_____

For women: Are you using a prescribed method of birth control? Yes ____ No _____

Are you pregnant? Yes____ No_____

Are you nursing? Yes____ No_____

Gramercy Smiles

A Holistic Approach to Dentistry

Esthetic Questionnaire

1. How do you feel about the appearance of your teeth/smile? _____
_____

2. Is there anything about the shape/size/alignment of your teeth you would like to change? _____

3. Would you like whiter teeth? **Yes** **No**

4. Have you considered any cosmetic dental procedures that you would like to discuss today? _____

5. Are you or have you considered Invisalign to correct misalignment? Would you like to address these issues today? _____

6. Did you ever have Invisalign? **Yes** **No** Age _____

7. Are there any other concerns you have pertaining to your teeth that you want to discuss with us today? _____

TMJ History

1. Have you ever had a problem or injury with your TMJ? **Yes** **No**
2. Do you experience pain in your TMJ when eating or speaking? **Yes** **No**
3. Do you hear clicks or pops in your TMJ? **Yes** **No**
4. Does your jaw ever get stuck or locked? **Yes** **No**
5. Do you have difficulty opening your jaw? **Yes** **No**
6. Does your jaw ever feel tired, heavy, or sore in the **AM/PM/both**?