Grossi Dental and Wellness

Bobby J. Grossi, DDS
And Associates

Welcome to our Practice!

Patient name: _____
Last First Middle

Gender: Male___ Female___ Birth Date: _____

Family Status: Married ___ Single ___ Child___ Other___ SS#_____

Email Address: _____

Phone: Home _____ Cell _____ Work _____

Address: _____ City_____ State_____ Zip Code_____

What is the best way to contact you? Text ☐ Email ☐ Mail ☐
(Please choose 2-3 options and rank
In order of preference) Phone: Cell ☐ Work ☐ Home ☐

Whom may we thank for referring you? _____

Emergency Contact: Name: _____ Phone: _____

Responsible Party Information

SAME AS ABOVE ___

Patient name: _____
Last First Middle

Gender: Male___ Female___ Birth Date: _____

SS#_____ Email Address: _____

Phone: Home _____ Cell_____ Work_____

Address: _____ City_____ State_____ Zip Code_____

Employment Information

Employer Name: _____ Phone: _____

Address: _____ City_____ State_____ Zip Code_____

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Medical and Dental History

Patient name: _____
Last First Middle

Do you consider yourself to be in fairly good health? Yes___ No___

Date of your last medical exam: _____

What is the name, address, and phone number of your primary care physician?

_____

Have you ever had complications following dental treatment? Yes___ No___

If yes please explain _____

_____

Are you currently under the care of a physician due to a specific condition? Yes___ No___

If yes please explain:

_____

_____

Do you use tobacco (smoking or chewing)? Yes___ No___

Are you pregnant? No___ Yes___ Due date: _____

Are you taking birth control pills? Yes___ No___

Do you take any vitamins or nutritional supplements? Yes___ No___

If yes please list _____

Please indicate if you have any allergies:

_____

_____

Please "X" if you have, or have had, any of the following:

Acid Reflex/GERD		Arthritis		Asthma		Dizziness	
Blood Disease		Diabetes		Emphysema		Head Injury	

Heart Murmur		HIV/AIDS		Artificial Joint or Valve		Herpes/ Cold Sores	
Hepatitis or other Liver Disease		Ulcers		High Blood Pressure		Excessive Bleeding	
Respiratory Problems		Anemia		Kidney Disease		Glaucoma	
Mitral Valve Prolapse		Tuberculosis		Radiation Treatment		Rheumatic Fever	
Stomach Problems		Pacemaker		Heart Disease		Jaundice	
Mental Disorders		Epilepsy		Sinus Problems		Stroke	
Cancer							

Are you taking any of the following?

Antibiotics or sulfur drugs		Cortisone / Steroids	
Insulin/ diabetes drugs		Aspirin/Blood Thinners	
High blood pressure meds		Osteoporosis medication	
Antidepressants/ tranquilizers		Pain Medication	

If you checked any of the medications, please explain (dosage, frequency, etc.)

When was your last visit to the dentist? _____

Please answer Yes or No:	YES	NO		YES	NO
Have you had any reactions to local anesthetics?			Have you had braces?		
Have you whitened/ bleached your teeth?			Are any teeth currently in pain?		
Are teeth sensitive to hot/ cold?			Do you grind your teeth?		
Do your gums bleed when you brush/floss?			Are any teeth loose?		
Do you have problems chewing?			Do you have pain with jaw joint?		
Does food get caught between your teeth?			Do you currently have any dental implants, dentures, or partials?		
Do you wear, or have you worn, a bite appliance?			Have you ever felt self-conscious about the appearance of your teeth?		
Do you snore?			Have you ever been diagnosed with sleep apnea?		

I acknowledge that I have reviewed ALL questions/ alerts on my health history and have responded accordingly. There are not other medical conditions, medications, or allergies that have not been listed. I am aware that I must notify the practice of any further changes. **Initials**_____

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Primary Dental Insurance

Name of Insured: _____
Last, First, Middle

SS#_____

Insured's Birth Date: _____ ID# _____ Group # _____

Insured's Address: _____
City State Zip

Insured's Employer Name:
_____

Patient's relationship to insured: Self__ Spouse__ Child__ Other__

Insurance Plan Name: _____

Secondary Dental Insurance

Name of Insured:
_____
Last, First, Middle

Insured's Birth Date: _____ ID# _____ Group # _____

Insured's Address:
_____
City State Zip

Insured's Employer Name: _____

Patient's relationship to insured: Self__ Spouse__ Child__ Other__

Insurance Plan Name: _____

Insurance Authorization:

__I authorize my dental benefits provider to pay the dentist all benefits rendered.

__I authorize the use of this electronic signature in all insurance submissions.

__I authorize the dentist to release all information necessary to secure the payment of benefits.

__I understand that I am financially responsible for all charges whether or not paid by dental benefits provider.

_____Initials

Grossi Dental and Wellness

Financial Policy

Gateway Dental is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All patients must complete ALL of our Patient Information Form before seeing the dental professional.
- Full payment is due at time of service, or anticipated copays from your insurance plan.
- We accept cash, checks, American Express®, VISA®, MasterCard®, Discover®, CareCredit®, Gateway Dental advantage discount plan, and Gateway Dental gift cards.
- Gateway Dental provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service.

Adult Patients: Adult patients are responsible for full payment at time of service. _____ **Initial**

Minors Accompanies by an Adult: The adult **accompanying** a minor, his/her parents or guardians are responsible for full payment at time of service. _____ **Initial**

Unaccompanied Minors: The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to American Express, VISA, MasterCard or Discover. _____ **Initial**

Insurance: Gateway Dental provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Gateway Dental staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to Gateway Dental. However, if you are paid by the insurance company instead of Gateway Dental, you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You, as a patient, are always responsible for any charges that are not covered by your insurance. _____ **Initial**

Delinquent Payments: It is our policy to charge finance fees at 1.5% per month for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00. _____**Initial**

Missed Appointments: Unless cancelled at least 48 hours in advance, we may charge for missed appointments at the rate of $35.00 per each 30 minutes of missed appointment time. Please help us service you better by giving us 48 hours-notice to alter an appointment. _____ **Initial**

I understand the above information and agree with its contents, and this will serve as my electronic signature for the administration

Signature: _____ **Date:** _____

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Consent for Internet Communications

I grant my permission to Gateway Dental and/or such associates or assistants to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured website for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice and grant the dental practice permission to securely upload my patient information to the web site.

Name of patient, parent, or guardian completing this form: _____

Relationship to Patient: _____

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

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Consent for treatment

I hereby authorize the doctors(s) and/or designated staff to take x-rays, study models, photographs and other diagnostic aids that deemed necessary and appropriate to make a through diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor(s) to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of local anesthetics and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a full recital of any possible complications.

Name of Patient, Parent, or Guardian completing this form: _____

Relationship to patient: _____ Date: _____

HIPAA Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.
To comply with one of the HIPAA requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse / neglect investigation.
From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

Please sign this form below under the heading "acknowledgment" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____ _____
Patient or Parent/Guardian Signature Patient Name (Please Print) Date

***Special instruction regarding communication from Gateway Dental:**

***Individual/s authorized to access account information:**