Patient Acknowledgement and Financial Policy Form
GRAND ISLAND DENTAL CENTER, LLC

We are happy to help you file and optimize your dental insurance if you are fortunate enough to have coverage. Please be aware that some dental procedures may not be covered by your dental plan. These procedures could be, but not limited to, certain dental materials, x-rays and other services. As a patient, you are responsible for the amount that your insurance company does not cover.

All patients, whether you have insurance or not, will be subject to a finance charge of 18% APR after 60 days. It is our office policy that payment in full is due upon completion of treatment. We appreciate your acknowledgement and understanding of this matter.

____ ____________________

Signature of Patient, Parent, or Guardian *Date*

GRAND ISLAND DENTAL CENTER

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

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 acknowledgement could not be obtained because:

- **Individual refused to sign**
-
- **Communications barriers prohibited obtaining the acknowledgement**
-
- **An emergency situation prevented us from obtaining acknowledgement**
-
- **Other (Please Specify**

Grand Island Dental Center

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: **PATIENT GIVING CONSENT**

Name:_______________________________

ADDRESS:_______________________________________

Section B: To the patient-Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read out Notice of Privacy Practices before you decide whether to sign the consent. Our notice provides a description of our treatment, payment activities and healthcare operations of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Persons: Dr. Mindy Rief or Dr. Dani Myers
Telephone: 308-382-7813
Address: 3568 Innate Lane Suite D, Grand Island, NE 68803

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________ have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that by signing this Consent Form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:______________________________________ Date:____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____________________________________

Relationship to Patient:___________________________________

GRAND ISLAND
DENTAL CENTER

MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: ______
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: ______
Have you ever had a serious head or neck injury? Yes No If yes, please explain: ______
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: ______
Do you take a blood thinner such as Aspirin or Coumadin? Yes No If yes, please explain: ______
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes, please explain: ______
Are you on a special diet? Yes No If yes, please explain: ______
Do you use tobacco? Yes No If yes, please explain: ______
Do you use controlled substances? Yes No If yes, please explain: ______

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ______

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Do you have, or have you had, any of the following?

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problem	Yes No	Fréquent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? Yes No If yes, please explain: ______

Any additional health information: ______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medica status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________ **DATE** ______

GRAND ISLAND
DENTAL CENTER

PATIENT REGISTRATION

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: ______

Patient Information

Address: ______ Address 2: ______

City: ______ State / Zip: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: ______ Age: ______ Soc. Sec: ______ Drivers Lic: ______

E-mail: ______ I would like to receive correspondences via ☐ Text ☐ Email

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

Employer: ______

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Pref. Dentist: ______

Pref. Hyg.: ______

Pref. Pharmacy: ______

How did you hear about our office: ______

Emergency Contact

Name: ______

Relationship to Patient: ______

Phone number: ______

Primary Insurance Information

Name of Insured: ______ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Ins. Company: ______

Address: ______

Group Number: ______

Employee ID #: ______

Secondary Insurance Information

Name of Insured: ______ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Ins. Company: ______

Address: ______

Group Number: ______

Employee ID #: ______