New Patient Registration

Today's Date _____/_____/_____

Patient name _____ Preferred: _____

SS# _____-_____-_____ Birth date _____/_____/_____ Age _____

If Minor: Mom _____ Phone # _____

Dad _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Home (_____) _____-_____ Work # (_____) _____-_____

Cell # (_____) _____-_____ Receive Text Messages: Yes ___ No ___

Email Address _____

Occupation _____ Employer _____

Circle One: Single Married Separated Divorced Widowed Student at _____

Previous Dentist's Name_____ Phone # _____

Whom May We Thank For This Referral _____

Emergency Contact _____ Relationship to Patient _____

Home/Work # (_____)_____-_____ Mobile # (_____)_____-_____

Dental Insurance

Name of Insured _____ Employer _____

Name of Dental Insurance Company _____ Phone # (_____)_____-_____

Address _____

Policy or Group # _____ SS/ID # _____ Birth date _____/_____/_____

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been patient in the hospital during the past two years?..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO
   Physician's Name _____
   Address _____ Telephone _____
4. Have you taken any medications or drugs during the past two years? ..... YES NO
5. Are you now taking any medications, drugs or pills?..... YES NO
   If yes, please list: _____
   _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medications or Substances? ..... YES NO
   If yes, please list: _____
7. Indicate which of the following you have had or have present. Circle "yes" or "no" to each item.

Heart Failure ..... YES NO	Stroke ..... YES NO	Hepatitis A (infectious) ..... YES NO
Heart Disease or Attack ..... YES NO	Artificial Joints (hip, knee,ect.)..... YES NO	Hepatitis B (serum) ..... YES NO
Angina Pectoris ..... YES NO	Kidney Trouble ..... YES NO	Venereal Disease ..... YES NO
Congenital Heart Disease ..... YES NO	Ulcers ..... YES NO	A.I.D.S. ..... YES NO
Heart Murmur ..... YES NO	Diabetes ..... YES NO	H.I.V. Positive ..... YES NO
High Blood Pressure ..... YES NO	Thyroid Problems ..... YES NO	Cold Sores/Fever Blisters ..... YES NO
Arteriosclerosis ..... YES NO	Glaucoma ..... YES NO	Blood Transfusion ..... YES NO
Mitral Valve Prolapse ..... YES NO	Cosmetic Surgery ..... YES NO	Hemophilia ..... YES NO
Heart Valve ..... YES NO	Emphysema ..... YES NO	Anemia ..... YES NO
Heart Pacemaker ..... YES NO	Chronic Cough ..... YES NO	Sickle Cell Disease ..... YES NO
Heart Surgery ..... YES NO	Tuberculosis ..... YES NO	Bruise Easily ..... YES NO
Rheumatic Fever ..... YES NO	Asthma ..... YES NO	Liver Disease ..... YES NO
Arthritis ..... YES NO	Hay Fever ..... YES NO	Yellow Jaundice ..... YES NO
Rheumatism ..... YES NO	Allergies or Hives .....YES NO	Epilepsy or Seizures ..... YES NO
Pain in Jaw Joints ..... YES NO	Sinus Trouble ..... YES NO	Fainting or Dizzy Spells ..... YES NO
Cortisone Medicine ..... YES NO	Radiation Therapy ..... YES NO	Nervousness ..... YES NO
Drug Addiction ..... YES NO	Chemotherapy ..... YES NO	Psychiatric Treatment ..... YES NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the past year/ ..... YES NO
12. Do you every wake up from sleeping and feel short of breath? ..... YES NO
13. Are you on a special diet? ..... YES NO
14. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
15. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO
    If yes please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

I authorize Dr. Grigsby and his assistant to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health/dental care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits and the payment of insurance benefits directly to the doctor, otherwise payable to me. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made. **I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days.** In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collections of this note.

Patient Signature _____ Date _____/_____/_____

Parent or Responsible Party _____ Relationship to Patient _____

Louis Grigsby, DDS
7424 Greenville Ave, Suite 111
Dallas, TX 75231

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.

Signature_____ Date _____/_____/_____

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy, but acknowledgement could not be obtained because

____ Individual refused to sign
____ Other Please Specify_____
____ Communication barriers prohibited obtaining the acknowledgement
____ An Emergency situation prevented us from obtaining acknowledgement

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENT 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 options.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may 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 ever change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the change.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and 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. I give the following person (s) authorization to obtain information about me.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Signature: _____ Date _____/_____/_____

If this is signed by a personal representative on behalf of the Patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

Louis Grigsby, DDS
7424 Greenville Ave, Suite 111
Dallas, TX 75231

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 06/03/2003 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 to our privacy practices, we will change this Notice and make the 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 or disclose your 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 anytime. 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 disclosed 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 to 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 indentifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or discloser of your health information, we will provide you with an opportunity to object to such uses or disclosers. 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 practices 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 of safety of others.

National Security: We may disclose to military authorities the health of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, 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, text messages, emails, letters, or postcards).

PATIENT RIGHTS

Access: You 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 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 $1.00 for each page, $25.00 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 alternate 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 this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, 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.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

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 to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at 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 Services.

Contact Officer: Louis Grigsby, DDS
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Fax: 214-361-0469
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Dallas, TX 75231
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