Joseph Gruber DDS and Associates LTD.
PATIENT INFORMATION FORM

First Name _____ Middle Name _____ Last Name _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____/_____/_____ Marital: **S M D W** Sex: **M F** Email _____
Referred by _____
How would you like to receive appointment reminders? (Please circle one) Voicemail Text Message Email
Home Phone: _____ May we leave a message at this number? **Yes No**
Cell Phone: _____ May we leave a message at this number? **Yes No**
Emergency Contact _____ Relationship _____ Phone _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relationship to patient _____ Soc. Sec.# _____
Address _____ City _____ State _____ Zip _____
Phone _____ May we leave a message? **Y N** Employer _____

PRIMARY DENTAL INSURANCE INFORMATION

We are *Out of Network* with all insurance companies. *Co-pay is due the time of appointment.*

Policyholder's Name _____ Policyholder's Date of Birth _____/_____/_____
Relationship to Patient _____ Policyholder's Employer _____
Insurance Company Name _____ Policyholder's Subscriber ID _____
Group Number _____

SECONDARY DENTAL INSURANCE INFORMATION

Policyholder's Name _____ Policyholder's Date of Birth _____/_____/_____
Relationship to Patient _____ Policyholder's Employer _____
Policyholder's Soc. Sec. # _____ Insurance Company Name _____

Regarding Dental Insurance: It is important that we inform you that our services are charged to the patient, not an insurance company. As a courtesy we will send all charges to your insurance company. Dental insurance pays only a portion of your investment, and we urge you to be aware of the provisions of your policy.

MEDICAL HISTORY

Medical Doctor's Name: _____ **Date of last physical exam:** _____
Date of last dental exam(for new patients): _____ **Preferred Pharmacy:** _____
Current Medications including any supplements: _____

Surgical History: _____

Have you ever had any of the following? (Continued on next page)

Anemia	**Clotting Disorder**	**Heart Condition**	**Joint Replacement**	**Renal Insufficiency**
Autoimmune Disorder	**Cough (Persistent)**	**Hepatitis**	**Latex Allergy**	**Respiratory Disorder**
Blood Transfusion	**Currently Pregnant**	**Herpes**	**Migraines**	**Rheumatic Fever**
Cancer	**Diabetes**	**High Blood Pressure**	**Pacemaker**	**Stroke**
Chemical Dependency	**Epilepsy**	**HIV/AIDS**	**Radiation Treatment**	**Tuberculosis**

Do you have any allergies or reactions to any drugs, medications, or anesthetics? _____

Any other conditions to be aware of? Please list: _____

AUTHORIZATION & CONSENT FOR TREATMENT

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 the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The finance charge will be a periodic rate of 1.5% per month, after 90 days. This is an annual percentage rate of 18% applied to the last month's balance. I understand that failure to pay will result in the use of legal representation and that I will be responsible for all fees incurred. The information on this page and the medical history are correct to the best of my knowledge. I understand that if I cannot attend my appointment, I will give 48 hour notice, or there may be a minimum of $50 charge. I hereby agree to the above terms.

Signature of Responsible Party:_____**Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

I, _____, am the personal representative and have legal authority to make health care decisions about the following patient:

Patient Name:_____

Authorized Representative (please print)_____

Signature_____**Date**_____

AUTHORIZATION FOR ADDITIONAL DISCLOSURE

I authorize the following individuals to have access to my health information.

Name: Relationship:

_____

_____

_____

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

_____Communication barriers prohibited obtaining acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (Please Specify) _____