

Dr. Jay S. Grossman's & Associates' Dental Practice

Patient Registration



Welcome to our practice! Dental care is more than repair. It is maintaining your best dental health. This is done by restoring your teeth so that they are comfortable, functional and attractive, treating your gum tissue health to last your lifetime and evaluating your general health and habits that may affect your future dental health.

Your answers to the following questions are the first step in determining your immediate and long-term dental care. Please add any comments that you might have... the more we know about your needs and concerns, the better we can serve you. Thank you!

- 1) This office practices state-of-the-art sterilization
- 2) We DO NOT discriminate

How did you find out about us? Our practice grows by referrals from our dental family. Who may we thank for referring you to our practice for your dental care?

Referral Source: _____

Date: _____ / 2012

Personal Information

Title	_____	Sex (circle one)	[Male] [Female]	Birth Date	_____
First Name	_____	Soc. Sec. #	_____		
Middle Initial	_____	Mobile Phone	_____		
Last Name	_____	Home Phone	_____		
Address	_____	Work Phone	_____		
City	_____	Email	_____		
State	_____	EmergContactName	_____		
Zip Code	_____	Contact Phone	_____		

Employer Information

Employer	_____	Phone	_____
Address	_____	Occupation	_____

Insurance Information

Insurance Company	_____	Group #	_____
Ins. Co. Address	_____	Ins. Co. Phone	_____

If Patient is not the insured	Insured's Name	_____	Soc. Sec. #	_____
	Insured's Hm Address	_____	Email	_____
	Insured's Wk Address	_____	Employee ID#	_____
		_____	Birth Date	_____
		_____	Work Phone	_____

How do you prefer to be contacted? (circle all that apply)

[Home] **[Work]** **[Mobile]** **[Email]**

Dr. Jay S. Grossman & Associates
 11980 San Vicente Blvd., Suite 507
 Brentwood, CA 90049
 Tel. 310.820.0123 * Fax. 310.207.3784
 www.drjaydds.com



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MEDICAL HISTORY

Date: / 2012

Patient Name _____

Physician Name _____

Physician Phone Number _____

Hospital or Serious Illness in Last 5 Years	Yes___ No___	Pace Maker	Yes___ No___
AIDS/Other Immunosuppressive Disorders	Yes___ No___	Women: Pregnant?	Yes___ No___
Allergies/Asthma	Yes___ No___	Due Date _____	
Arthritis, Rheumatism	Yes___ No___	Nursing?	Yes___ No___
Artificial Heart Valves	Yes___ No___	Psychiatric Care/Treatment	Yes___ No___
Artificial Joints	Yes___ No___	Radiation Treatment	Yes___ No___
Abnormal Bleeding w/ Extractions/Surgery	Yes___ No___	Rheumatic Heart Disease	Yes___ No___
Cancer	Yes___ No___	Scarlet Fever	Yes___ No___
Chemical Dependency	Yes___ No___	Sinus Trouble	Yes___ No___
Chemotherapy	Yes___ No___	STD/Venereal Disease	Yes___ No___
Diabetes	Yes___ No___	Stroke	Yes___ No___
Epilepsy Fainting or Seizures	Yes___ No___	Swollen Glands	Yes___ No___
Glaucoma	Yes___ No___	Thyroid Disorder	Yes___ No___
Headaches	Yes___ No___	Tonsillitis	Yes___ No___
Heart Murmur/Heart Disorder	Yes___ No___	Transfusion	Yes___ No___
Hepatitis	Yes___ No___	Tuberculosis	Yes___ No___
Herpes	Yes___ No___	Tumor or Growth on Neck or Head	Yes___ No___
High Blood Pressure	Yes___ No___	Ulcers	Yes___ No___
Low Blood Pressure	Yes___ No___	Unexplained Weight Loss	Yes___ No___
Kidney Disease	Yes___ No___	Have you ever taken Fen-Phen?	Yes___ No___
Any Operations in Last 5 Years?	Yes___ No___	Latex Allergy?	Yes___ No___
Liver Disease	Yes___ No___		

List any medications you are currently taking: _____

List any allergies you have: _____

Pharmacy Name _____ Pharmacy Phone _____

Date of last eye exam _____ Optometrist Name _____

To the best of my knowledge, the questions on this form have been understood by me and accurately answered. I understand that providing incorrect information can be dangerous to my health. It is MY RESPONSIBILITY to inform the dental office of any changes in my medical status. I will NOT hold my Dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____

Dentist Signature _____

Date _____

Date _____

The information documented in this form remains strictly confidential and will not be shared with third parties without the consent of the patient.



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DENTAL HISTORY

Date: / 2012

Patient Name _____ Former Dentist Name _____

Former Dentist Phone Number _____

Reason for Today's Visit _____

Date of Last Dental Visit _____ Date of Last Dental X-Rays _____

Indicate if you had or are currently aware of any of the following:

Bad Breath	Yes ___ No ___	Food Collection Between Teeth	Yes ___ No ___
Bleeding Gums	Yes ___ No ___	Grinding Teeth/Clenching	Yes ___ No ___
Blisters on Lips or Mouth	Yes ___ No ___	Gums Swollen or Tender	Yes ___ No ___
Are you missing teeth?	Yes ___ No ___	Loose Teeth or Broken Filling	Yes ___ No ___
Cigarette Smoking	Yes ___ No ___	Orthodontic Treatment	Yes ___ No ___
Clicking or Popping Jaw	Yes ___ No ___	Periodontal Treatment	Yes ___ No ___
Dentures/Partial Dentures	Yes ___ No ___	Sensitivity to Heat or Cold	Yes ___ No ___
Dry Mouth	Yes ___ No ___	Sores or Growths in Mouth	Yes ___ No ___
Finger Nail Biting	Yes ___ No ___		
Do you snore?	Yes ___ No ___		
Does your partner snore?	Yes ___ No ___		

How often do you brush? _____ Are you satisfied with the whiteness of your teeth? Yes ___ No ___
 How often do you floss? _____ Are your teeth straight enough for you? Yes ___ No ___
 Are you satisfied with your smile? Yes ___ No ___

To avoid any misunderstanding regarding your dental insurance, we wish our patients to know that **all professional services are charged directly to the patient and that patients are personally responsible for payment of fees.** We do not render services on the basis that the insurance companies will pay our fees. We will assist you in filing all insurance forms. **Payment is due when services are rendered unless other arrangements have been made.** Our policy for missed appointments or appointments cancelled with less than 48 hours notice is as follows: \$100 or 10% of that day's scheduled treatment, whichever is higher. We appreciate the opportunity to serve you and hope you understand our implementation of cost controls such as these.

I hereby authorize Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of medication, and therapy that may be indicated and agreed upon. **All balances over 30 days are subject to a 1.5% monthly service fee.**

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement. I understand that responsibility for payment for dental services provided in this office for me or my dependents is mine, due and payable, at the time services are rendered.

Patient Signature _____ Dentist Signature _____

Date _____ Date _____

Updated Health History - This section is for FUTURE updates, please do not sign at this time.

Patient Signature _____ Dentist Signature _____

Date _____ Date _____

Patient Signature _____ Dentist Signature _____

Date _____ Date _____



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Medical History Update

Date: / 2012

Updated Health History- This section is for FUTURE updates, please do not sign at this time.

Patient Signature _____ Dentist Signature _____

Date _____ Date _____

Changes _____

Updated Health History- This section is for FUTURE updates, please do not sign at this time.

Patient Signature _____ Dentist Signature _____

Date _____ Date _____

Changes _____

Updated Health History- This section is for FUTURE updates, please do not sign at this time.

Patient Signature _____ Dentist Signature _____

Date _____ Date _____

Changes _____

Updated Health History- This section is for FUTURE updates, please do not sign at this time.

Patient Signature _____ Dentist Signature _____

Date _____ Date _____

Changes _____

Updated Health History- This section is for FUTURE updates, please do not sign at this time.

Patient Signature _____ Dentist Signature _____

Date _____ Date _____

Changes _____

Dr. Jay S. Grossman and Associates

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____

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. **We will never sell or disclose your personal information to outside parties.** We may use personal information for Dental Insurance claims and collection activities.

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 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 Person: Theresa Kimbro, Office manager

Telephone: 310/820-0123 Fax: 310/207-3784

E-mail: drjaydds@mac.com Address: 11980 San Vicente Blvd., Suite 507; LA, CA 90049

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: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. This completed Consent must be kept in the patient's chart. Jan 2012



Dr. Jay Grossman & Associates
Risks & Policies for dental care at our office &
confidentiality & Public posting policy

RECORDS: I authorize Dr Grossman & Associates, or staff, to take digital images, models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize email communications at the email address I provided.

CHANGE IN TREATMENT PLAN: during treatment it may be necessary to change the original treatment plan due to conditions found while working that were not discovered during exam. The most common is the need for a root canal on a tooth that is being prepared for a crown.

FILLINGS: dental fillings may require additional treatment, such as root canals or crowns.

DENTAL CLEANINGS: deep cleanings in particular may result in sensitivity, that mostly resolves in a few days, or may need a periodontal referral if not resolved.

COSMETIC PROCEDURES: may result in exposed nerves or sensitivity that may require root canals. Veneers have a chance of falling off and may require re-cementation, or a change to a full crown. We warranty veneers for 1 – year, which we will replace at no charge if they fail.

ROOT CANALS: complications include a broken instrument inside the canal that we cannot retrieve, or a fractured root, and may require re-treatment or extraction.

CROWNS / BRIDGES: sometimes it is difficult to get an exact color match so we may need to refer you to the lab for a custom color selection. Sometimes porcelain may chip on a crown or the glue no longer holds. If a crown or bridge fails within the first year, we will replace it at no charge. If it fails in year 2 or 3, there will be a nominal charge of \$300 per tooth to restore it. In short, we warranty our crowns for the first 3 years providing you keep **all three of your dental re-care** cleaning appointments annually.

Confidentiality & Public Postings:

“Dr. Grossman and Patient understand that all matters relating to treatment and care provided are confidential. Therefore, Patient agrees to promptly address any and all concerns relating to Patient’s treatment directly to Dr. Grossman & Associates who will make every effort to promptly resolve any such concerns with Patient to the extent possible. Patient further agrees not to publicize any concerns relating to treatment provided to Patient by Dr. Grossman & Associates without, at a minimum, first providing Dr. Grossman & Associates an opportunity to resolve the concerns. This provision in no way is intended to limit or prevent the Patient from making any formal administrative complaints to any relevant governmental or regulatory entity. Patient further agrees that should the Patient publicize any complaints or concerns in any forum (i.e. internet websites, blogs, chat groups, newspapers, etc.), Patient shall be deemed to have expressly waived confidentiality relating to Patient’s treatment with Dr. Grossman & Associates. Should Patient publicize any complaints or concerns relating to treatment and care provided by Dr. Grossman & Associates, Dr. Grossman & Associates shall have the right to publicly respond to any complaints or concerns published by Patient in any forum. Patient further agrees that Patient’s election to publish any complaints or concerns in any forum shall constitute a waiver of Patient’s rights under the Health Insurance Portability and Accountability Act (HIPAA), to the extent such Act applies to treatment and care provided by Dr. Grossman & Associates to Patient.”

X _____ Date: _____

Signature of patient: I have reviewed the risks benefits and options of the basic general dentistry procedures & agree to the confidentiality & Public posting policy