Grove Smiles Dentistry

Thank you for selecting Grove Smiles Dentistry. We will strive to provide you with the best possible dental health care. To help us meet all your dental care needs, please fill out this form completely. If you have any questions or need assistance, we will be happy to help.

Stephen J. Parr, DDS, PA **Rita Dargham, DMD.**

DENTAL REGISTRATION AND HISTORY

Today's Date _____

Name _____ Social Security# _____-_____-_____

Address _____ City _____

State _____ Zip Code _____ Home Phone ( ) _____

Email Address _____@_____ Cell Phone ( ) _____

Choice of contact ☐ Text ☐ E-mail ☐ Phone call ☐ Any ☐ Other_____

Sex: ☐ Male ☐ Female, Date of Birth _____ Age _____

☐ Single ☐ Married ☐ Domestic Partners ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse_____

Emergency Contact _____ Phone ( ) _____

Relationship to Patient_____

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Who may we thank for referring you? _____

DENTAL INSURANCE

Name of Insured _____ Social Security# _____-____-_____

Relationship to Patient. _____ Date of Birth of Insured. _____

Insured Employed By _____

Name of Insurance Company _____

2685 Bird Ave Coconut Grove, FL 33133, 305-858-0505, 305-858-3223 (FAX)

Phone of Insurance Company ( ) _____

Group# _____ Member ID # _____

DENTAL HISTORY

Reason for Today's Visit _____ Date of Last Dental Care _____

Date of Last Cleaning _____ Date of Last Dental X -rays _____

Do you have a specific dental problem? If so, please describe_____

_____

Please check if you have had any of the following:

☐ Bad Breath ☐ Food collection between teeth ☐ Limited jaw motion

☐ Bleeding gums ☐ Grinding ☐ Loose teeth

☐ Braces ☐ Gum Treatment ☐ Painful Jaw

☐ Broken teeth/ broken fillings ☐ Headaches ☐ Pain when biting or chewing

☐ Clenching ☐ Jaw Locking ☐ Oral Surgery

☐ Facial Pain Joint Sounds (Clicking or popping) ☐ Sensitivity to hot/cold/sweets

☐ Other:_____

COSMETIC EVALUATION

Are you happy with your smile?_____ Would you like to have whiter teeth? _____

Would you like to straighten your teeth? ☐ Are you interested in porcelain veneers? ☐

Would you like to learn about your options to replace missing teeth? ☐

Have you had Botox/Dysport and/or Dermal Fillers (Juvederm/Restylane/Perlane/

Radiesse) in the past? ☐ Would you be interested? ☐

What additional services would you like to learn about? Please check all that apply:

☐ Clenching/Grinding treatment ☐ Veneers

☐ Repairing broken/fractured teeth ☐ Facial Injectables/Fillers

☐ Replacing missing teeth/implants ☐ Improvement of facial fine lines/wrinkles

☐ Straightening crowded teeth ☐ Teeth Whitening ☐ Invisalign/braces

☐ Smile Design ☐ Other _____

MEDICAL HISTORY

Physician's Name _____ Physician's Phone ( ) _____

Date of Last Physical Exam:_____

Have you ever had any of the following? (check boxes that apply):

☐ Abnormal Bleeding ☐ **Congenital Heart Defect** ☐ Hemophilia ☐ Shingle's

☐ Alcohol Abuse ☐ Diabetes ☐ Hepatitis *AIBIC* ☐ Sinus Problems ☐ Acid Reflux

☐ Allergies ☐ Difficulty Breathing ☐ High Blood Pressure ☐ Stroke

☐ Anemia ☐ Drug Abuse ☐ HIV/AIDS ☐ Swollen Neck Glands ☐ Heart Murmur

☐ Angina Pectoris ☐ Emphysema ☐ Immune Disorder ☐ Thyroid Problems

☐ **Artificial Heart Valve** ☐ Epilepsy ☐ **Joint Replacement** ☐ Tuberculosis

☐ Arthritis ☐ Facial Surgery ☐ Kidney Problems

☐ Asthma ☐ Fainting spells ☐ Liver Disease/Jaundice

☐ Back Problems ☐ Fever blisters ☐ Low Blood Pressure

☐ Bisphosphonates ☐ Gastric Ulcers ☐ Mitral Valve Prolapse

☐ Blood Disease ☐ Glaucoma ☐ Pace Maker

☐ Cancer ☐ Headaches/Migraines ☐ Radiation Therapy

☐ Chemotherapy ☐ **Heart Attack** ☐ Rheumatic Fever

☐ Circulatory Problems ☐ Heart Surgery ☐ Seizures

☐ Surgeries_____

Women Only:

Are you taking Birth Control Pills [ ]

Pregnant [ ]

If Yes, # Weeks_____

Are you nursing [ ]

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

_____

_____

ALLERGIES

☐ Aspirin ☐ Local Anestheic ☐ latex

☐ Codeine ☐ Penicillin ☐ Sulfa Drugs

☐ **Others:**_____

_____

_____

_____

Use the back if there are more than the space allows for

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INSURANCE ASSIGNMENT AND RELEASE

I certify that I and/or spouse/dependent(s) have insurance coverage with

_____(Ins. Co. Name)

and assign directly to Stephen J. Parr, DDS, P.A., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of my signature on all insurance submissions.

The above named doctors may use my or my minor/child's health information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

FINANCIAL AGREEMENT

I acknowledge that payment is due to Stephen J. Parr, DDS, PA, at the time of treatment unless other arrangements are made prior to treatment. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I accept financial responsibility for a cancellation or “no show” made less than 24 hours in advance of the appointment, and for the $50.00 fee charged. Should the account be referred to an attorney for collection, I authorize said attorney to obtain my credit report; and the undersigned shall pay reasonable attorney's fees and collection expenses. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

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Grove Smiles Dentistry

NOTICE OF PRIVACY PRACTICE SUMMARY- HIPPA

This summary discloses how Healthcare information about you may be used by **Dr. Stephen J. Parr, DDS, PA.** and Grove Smiles Dentistry. A full notice of your privacy rights has been provided to you.

Treatment, Payment, Operations. We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Uses and Disclosures for Appointment Reminders. We may use and disclose your Healthcare information to contact you (see below) as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please express it in writing below. We will accommodate all reasonable requests.

Authorization for Use and Disclosure. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Public health, research, health and safety, government, works compensation. We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

Rights. You have a right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

Concerns. You may express concerns to **Dr. Stephen J. Parr, DDS at 305-858-0505** or to the Florida Department of Health and Human resources if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Organization duties. We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health

NOTICE OF PRIVACY PRACTICE SUMMARY- HIPPA

information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Questions. If you have any questions, please contact our office and the appropriate person will address your questions

Dr. Stephen J. Parr, DDS, PA
Grove Smiles Dentistry

_____	_____	_____
Patient Name (print)	Signature	Date
_____	_____	_____
Witness	Signature	Date

Appendix

Please call ☐ my home ☐ my work ☐ my cell Number:_____

If unable to reach me:
☐ you may leave a detailed message
☐ please leave a message asking me to return your call
☐ _____
The best time to reach me is (*day*)_____ between (*times*)_____