



*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 \_\_\_\_\_

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**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 *A/B/C*  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 Anesthetic  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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## 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

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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*)\_\_\_\_\_