GROVE SMILES® DENTISTRY

P@R? B?PEF?K* DKD

2685 BIRD AVENUE, COCONUT GROVE, FL 33133
PH: 305-858-0505 FAX: 305-858-3223
www.grove-smiles.com

Patient Information

Date_____

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name_____ M.I.____ Last Name_____ Nickname_____

Sex: ☐Male ☐Female Birthdate____/____/_____Age_____Soc.Security_____-____-_____ Driver's Lic_____

Street_____ Apt#_____ City_____State_____Zip_____

Home Tel (____)_____Cell (_____)_____Email_____

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

Student: ☐Full-Time ☐Part-Time School Name_____ School Address_____

Marital Status: ☐Single ☐Married ☐Domestic Partners ☐Legally Separated ☐Divorced ☐Widowed

Name of Spouse/Significant Other_____ Ph (____)_____

Employed: ☐Full-Time ☐Part-Time ☐Retired

Employer_____ Occupation_____Bus Ph (____)_____

Emergency Contact Name_____Relationship_____Ph (____)_____

Who may we thank for referring you? _____

Account Information

Who will be responsible for your account? ☐Self, skip this section ☐Spouse ☐Father ☐Mother ☐Other_____

Name _____ Soc.Security_____-____-_____ Birthdate____/____/_____ Age___ Ph (_____)_____

Street_____ Apt#_____ City_____State_____Zip_____

Employer _____Occupation_____ Bus Ph (____)_____

Dental Insurance Information

Do you have insurance that will cover any or part of our Professional services? ☐Yes, provide Ins Card and ID ☐No (Skip this section)

Name of Insurance Co._____Member Id/Policy #_____Group #_____

Name of Policy Holder (Subscriber)_____ Soc.Security_____-____-_____ Birthdate____/____/_____

Employer/Co _____ Relationship to Subscriber (if not self) _____ Subscriber's Ph (____)_____

Dental Information

Reason for today's visit: ☐New Patient exam ☐Emergency ☐Consultation ☐Other_____

Are you in pain: ☐Yes ☐No ☐Don't know

Please indicate any of the following problems by checking off the corresponding box:

☐Discomfort, clicking or popping jaw	☐Red, swollen or bleeding gum	☐Sensitive teeth or gums	☐Blisters/sore in or around mouth
☐Lost/broken fillings	☐Teeth grinding, clenching	☐Ringing in the ears	☐Broken/chipped tooth
☐Stained teeth	☐Locking jaw	☐Bad breath	☐Burning tongue/lip
☐Difficulty closing jaw	☐Swelling/lumps in mouth	☐Loose/shifting teeth	☐Food caught in between teeth
☐My teeth are sensitive to: ☐Hot ☐Cold ☐Sweets ☐Biting		☐Other _____	

Previous dentist: Name _____ Phone (_____)_____

Last dental cleaning: Date _____ Last dental x-rays: Date _____

Times a day you brush: _____ Times a day you floss _____ Type of toothbrush bristles you use: ☐Soft ☐Medium ☐Hard

How would you rate your smile? (worst) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (best)

(Please complete reverse side)

Medical Information

Are you taking any of the following medication or drugs: ☐Anti-amxiety ☐Pain ☐Muscle relaxant ☐Stimulant ☐Blood thinner ☐Insulin ☐Marijuana ☐Cocaine ☐Other _____

Do you have or have had any of the following diseases, medical conditions or procedures?

Y N		Y N		Y N		Y N		Y N	
☐☐	Heart attack/stroke	☐☐	Thyroid problems	☐☐	Cancer/tumors	☐☐	Cosmetic surgery	☐☐	Heart surgery/pacemaker
☐☐	Kidney problems	☐☐	Shingles	☐☐	X-ray or cobalt tx	☐☐	Heart murmur	☐☐	Liver problems
☐☐	Hepatitis	☐☐	Chemotherapy	☐☐	Rheumatic fever	☐☐	Respiratory prob	☐☐	HIV/AIDS/ARC
☐☐	Asthma	☐☐	Mitral Valve prob	☐☐	Sinus Problems	☐☐	Arthritis	☐☐	Difficulty breathing
☐☐	Artificial Valves	☐☐	Stomach ulcers	☐☐	Artificial joints	☐☐	Diabetes	☐☐	Heart disease
☐☐	Psychiatric prob	☐☐	Emphysema	☐☐	Leukemia	☐☐	Cong Heart Defect	☐☐	Venereal disease
☐☐	Fainting/seizures	☐☐	Anemia	☐☐	Chest pains	☐☐	Alcohol/drug abuse	☐☐	Severe/freq headaches
☐☐	High blood press	☐☐	Bleeding prob	☐☐	Scarlet fever	☐☐	Tuberculosis	☐☐	Neck pain
☐☐	Low blood press	☐☐	Nervousness	☐☐	Jaw problems	☐☐	Back prob	☐☐	Glaucoma

Please list any other medical condition you have or ever had:_____

Are you allergic to the following: ☐Latex ☐Penicillin ☐Tetracycline ☐Aspirin ☐Sulfa ☐Dental anesthetics ☐Other _____

Do you use tobacco? ☐Yes ☐No Packs/day____For how long?_____ Have you ever taken the drug Phen-Fen or Redux? ☐Yes ☐No

Please rate your general health: (worst) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (best)

For women only:

Are you taking birth control pills? ☐Yes ☐No Are you pregnant? ☐Yes ☐No How far along? _____ Are you nursing?☐Yes ☐No

I authorize Grove Smiles Dentistry Rita Dargham, D.M.D. to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and is correct and current to the best of my knowledge. I understand it is my responsibility to inform GSD of any changes to the information I have provided.

*Print Name*_____ *Signature*_____ *Date*_____

Date	Services	Charges	Credits	Balance

INSURANCE ASSIGNMENT AND RELEASE

I certify that I and/or spouse/dependent(s) have insurance coverage with _____(Ins. Co. Name) and assign directly to Rita Dargham, DMD, 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 Rita Dargham, DMD, 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 _____

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

Grove Smiles Dentistry

NOTICE OF PRIVACY PRACTICE SUMMARY- HIPPA

This summary discloses how Healthcare information about you may be used by **Dr. Rita Dargham, DMD** 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. Rita Dargham, DMD 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. Rita Dargham, D.M.D
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*)_____