Grant Parish D.D.S.
smiles@grantparishdds.com
www.grantparishdds.com
972.250.0900
972.250.3798 fax
4222 Trinity Mills, Suite 104
Dallas, Texas 75287

SMILE with CONFIDENCE

About You

Today's Date: E-mail Address:

Name: Last: First: Mi: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr

I prefer to be called: ☐ Male ☐ Female

Birthday: / / Age: Social Security #:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: Street: City: State: Zip:

Home Phone # : ( ) Pager/Car #: ( )

Work Phone # : ( ) Ext: Driver's License #:

Where & when are best times to reach you?

Whom may we thank for referring you?

Other family members seen by us:

Employer: How long there? Occupation:

Employer's Address: Street/P.O. Box City: State: Zip:

Neighbor or Relative not living with you: His / Her Name: Relation:

Home Phone # : ( ) Work Phone # : ( )

Address: Street: City: State: Zip:

Spouse Information

His/Her Name: Birthday: / / Social Security #:

Employer Work Phone#:( ) Ext

Driver's License #:

Insurance Information

Primary Insurance:

Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No

Insurance Co. Name: Phone #:( )

Group # (Plan, Local or Policy #)

Insurance Co. Address: Street: City: State: Zip:

Insured's Name: Insured's Social Security#:

Insured's Birthday: / / Insured's Employer:

Employer's Address: Street/P.O. Box City: State: Zip:

Secondary Insurance:

Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No

Insurance Co. Name: Phone #:( )

Group # (Plan, Local or Policy #)

Insurance Co. Address: Street: City: State: Zip:

Insured's Name: Insured's Social Security#:

Insured's Birthday: / / Insured's Employer:

Employer's Address: Street/P.O. Box City: State: Zip:

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Dental History

Why have you come to the dentist today? _____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Do your gums ever bleed? ☐ Yes ☐ No

Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else?

Do you have mobility in your teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

☐ Previous/ ☐ Present Dentist:

Last Visit Dale: / /

Would you like fresher breath? ☐ Yes ☐ No

Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks?
☐ Yes ☐ No if not, what would you change?

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:

Address: Street:

City: State: Zip:

Phone # : ( ) Date of last visit:

Your current physical health is:
☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain:

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Phen-Fen, Redux or Pondimin? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week # Are you nursing? ☐ Yes ☐ No

Do you or have you experienced the following? ☐ Y for yes, ☐ N for No

☐ Abnormal Bleeding	☐ Colitis	☐ Hay Fever	☐ Liver Disease	☐ Shingles
☐ Alcohol Abuse	☐ Congenital Heart Defect	☐ Headaches	☐ Low Blood Pressure	☐ Sickle Cell Disease
☐ Anemia	☐ Diabetes	☐ Heart Attack	☐ Lupus	☐ Sinus Problems
☐ Arthritis	☐ Difficulty Breathing	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Steroid Therapy
☐ Artificial Bones/ Joints	☐ Drug Abuse	☐ Heart Surgery	☐ Pacemaker	☐ Stroke
☐ Artificial Valves	☐ Emphysema	☐ Hemophilia	☐ Persistent Cough	☐ Thyroid Problems
☐ Asthma	☐ Epilepsy	☐ Hepatitis	☐ Psychiatric Problems	☐ Tonsillitis
☐ Blood Transfusion	☐ Ever Hospitalized	☐ Herpes	☐ Radiation Treatment	☐ Tuberculosis (TB)
☐ Cancer	☐ Fainting Spells	☐ High Blood Pressure	☐ Rheumatic Fever	☐ Ulcers
☐ Chemotherapy	☐ Fever Blisters	☐ HIV+/AIDS	☐ Scarlet Fever	☐ Venereal Disease
☐ Chicken Pox	☐ Glaucoma	☐ Kidney Problems	☐ Seizures	

Please list any serious medical condition(s) that you have experienced:

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No If yes, please list each one:

Are you allergic to any of the following? ☐ Y for yes, ☐ N for No

☐ Aspirin	☐ Codeine	☐ Erythromycin	☐ Latex	☐ Sedatives	☐ Tetracycline
☐ Barbiturates	☐ Dental Anesthetics	☐ Jewelry / Metals	☐ Penicillin	☐ Sulfa Drugs	☐ Other

Please list anything additional that causes allergic reactions:

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it Is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all Insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature Date

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Financial Policy

We at Dr. Parish's office are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental health care available today. In addition, we are also dedicated to making top-quality care as cost effective as possible.

We are experienced in handling dental insurance, and as a courtesy as well as a convenience to you, we will be glad to process your insurance claim for assignment of benefits. Although you have verified your eligibility, you will need to make certain that you are able to choose any dental doctor of your choice. We can only file your insurance if we can verify your dental coverage. Always keep in mind that payment of benefits is not guaranteed and should a claim be denied, the responsibility of payment will be yours. All deductibles and estimated patient portions will be due at the time services are rendered. Should insurance fail to pay a claim in a reasonable time period all balances will be transferred to the patient. Your dental insurance is an agreement between yourself and the insurance company, and ultimately all financial responsibility is yours.

To assist you with your healthcare investment, we provide the following payment options:

Payment Options:

1. Cash	Includes money orders and personal checks.
2. Credit Cards	We accept American Express, Discover, Master Card & Visa
3. Dental Insurance Benefits	As described above
4. CareCredit	The monthly payment plan we offer as a separate line of credit to cover your family members' healthcare needs.

With CareCredit:

- Approval usually only takes a few minutes
- We offer No Interest Options: You can make monthly payments as low as 3% of the outstanding balance for example
- We also offer low interest Extended Payment Plan options, for more time to pay your balance
- No annual fees or prepayment penalties

All fees must be paid in full at the time of service.

**Cash Incentive	for patients who file their own insurance and our cash patients a 5% discount will be given.

Signature Date

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a procedure may require that your relevant protected health information be disclosed to the dental plan to obtain approval for dental treatment.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to dental school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us

, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Signature Print Name Date

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Photographic Release

In our office we like to photograph our patients to aid in determining their problems and to help come up with the perfect treatment options for them. With these photographs, we can recreate your smile on the computer so that you can see the final results and approve of them before we start any procedure.

We are very proud of the work we have done and only use our own patients in our marketing and advertising. All of the portraits in our office, on our web site, www.grantparish.net , and in our ads are our own patients and photography.

AUTHORIZATION AND RELEASE

I _____ , hereby authorize Dr. Grant Parish to take photographs, slides, and / or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient Signature Date