G² Dental
family dentistry

Patient Registration

Date: _____

Patient Name:

_____
(Last) (First) (Mi)

Birthdate: _____

Home Address: _____
(Street) (City) (State) (Zip)

Telephone: Home: _____ Business: _____ Cell: _____

Email Address: _____

Employer Name: _____

Emergency Contact: _____ Phone Number: _____

Name Of Person Referred By: _____

Billing Instruction

Name of person
to be billed: _____ Relationship: _____

Address (if different): _____

Telephone: Home: _____ Business: _____ Cell: _____

Dental Insurance Company: _____

Subscriber ID: _____ Date of Birth: _____

Insurance Group Number: _____

Employer: _____

Are you covered by a second dental plan? Yes / No

If yes, Second Dental Insurance Company: _____

Subscriber ID: _____ Date of Birth: _____

Insurance Group Number: _____

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. All accounts are subject to a finance charge computed on the unpaid balance 90 days and over. Maximum periodic rate and annual percentage rate are determined by the laws of the patient's state of residence. In the event a finance charge may be made on your account, the periodic rate is 1.5% and the annual percentage rate is 18%.

Patient Signature: _____
(If patient is a minor, parent or guardian signature, please)

POS Reorder # 1916057

Medical Health History

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Patient's Name: _____

Date of Birth: _____

Physician Name: _____ Physician Telephone: _____

Physician Address: _____

Mark your response to indicate if you have had any of the following diseases or problems.
If you have a disease or problem that is not listed below, write the disease or condition in the space on the back of this form.

Date of last physical examination: _____

Yes	No	
☐	☐	Any changes in your health within the past year?

Yes	No	**Cardiovascular**
☐	☐	High/low blood pressure
☐	☐	Irregular heart beat
☐	☐	Heart surgery
☐	☐	Heart failure
☐	☐	Damaged heart valve
☐	☐	High cholesterol
☐	☐	Heart infection
☐	☐	Stroke
☐	☐	Rheumatic heart disease/ rheumatic fever
☐	☐	Heart defect/heart murmur
☐	☐	Heart trouble/heart attack/ angina
☐	☐	Chest pain
☐	☐	Pacemaker
☐	☐	Congenital heart problem
☐	☐	Mitral valve prolapse

Yes	No	**Hematologic**
☐	☐	Anemia
☐	☐	Sickle cell anemia
☐	☐	Abnormal bleeding
☐	☐	Taking blood thinners
☐	☐	Blood transfusion

Yes	No	**Respiratory**
☐	☐	Emphysema/bronchitis
☐	☐	Sleep apnea
☐	☐	Asthma/hay fever/ seasonal allergies
☐	☐	Lung/breathing problems
☐	☐	Sinus trouble
☐	☐	Shortness of breath
☐	☐	Scarlet fever
☐	☐	Persistent cough
☐	☐	Cough that produces blood
☐	☐	Tuberculosis
☐	☐	Tonsillitis

Yes	No	**Endocrine**
☐	☐	Diabetes
☐	☐	Thyroid problem
☐	☐	Hypoglycemia

Yes	No	**Renal**
☐	☐	Kidney disorder
☐	☐	Dialysis

Yes	No	**Immune**
☐	☐	Past use of steroids
☐	☐	Delayed healing

Yes	No	**Musculoskeletal**
☐	☐	Fibromyalgia
☐	☐	Lupus
☐	☐	Sjogren's Syndrome
☐	☐	Osteoporosis
☐	☐	Taken <u>any</u> meds for bone loss prevention, ie: Fosamax or Boniva
☐	☐	Arthritis/rheumatism
☐	☐	Joint replacement/implant

Yes	No	**Gastrointestinal**
☐	☐	Acid reflux/GERD
☐	☐	Irritable bowel syndrome
☐	☐	Stomach ulcer

Yes	No	**Hepatic**
☐	☐	Liver disease
☐	☐	Jaundice
☐	☐	Hepatitis

Yes	No	**Neurologic**
☐	☐	Epilepsy/seizures
☐	☐	Parkinson's Disease
☐	☐	Multiple sclerosis
☐	☐	Headaches/migranes

Yes	No	**Skin**
☐	☐	Hives or skin rash
☐	☐	Other skin lesions
☐	☐	Cold sores/fever blisters

Yes	No	**Eyes/Ears**
☐	☐	Glaucoma
☐	☐	Impaired vision/contact lens
☐	☐	Impaired hearing/hearing aids

Yes	No	**Mental Health**
☐	☐	Bipolar disorder
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Eating disorders
☐	☐	Sleep disorder
☐	☐	Dementia
☐	☐	Learning disorders
☐	☐	Mental health care
☐	☐	Nervousness

Yes	No	**Infections**
☐	☐	HIV positive/AIDS
☐	☐	Sexually transmitted disease

Yes	No	**Allergies**
☐	☐	Local anesthetic
☐	☐	Antibiotics/penicillin
☐	☐	Aspirin/ibuprofen
☐	☐	Acetaminophen (Tylenol)
☐	☐	Codeine/narcotics
☐	☐	Metals
☐	☐	Iodine
☐	☐	Latex
☐	☐	Sulfa drugs
☐	☐	Other _____
☐	☐	Food/environmental please list _____

Yes	No	**Other**
☐	☐	Cancer
☐	☐	Cancer treatment/Radiation
☐	☐	Chemotherapy (Cancer, Leukemia)
☐	☐	Tobacco use
☐	☐	Alcohol use
☐	☐	Chemical dependency
☐	☐	Street/recreational/illicit drug use
☐	☐	Back problems
☐	☐	Tumors
☐	☐	Swelling of feet/ankles/ hands
☐	☐	Fainting/dizzy spells
☐	☐	Cortisone treatment
☐	☐	Unexplained weight loss
☐	☐	Taken Redux

Please list any disease, condition, or problem you have that is not listed on the other side.

Please list any hospitalizations or surgeries you have had.

Please list all medications you are taking. (Including vitamins and supplements)

	YES	NO
Have you been diagnosed with sleep apnea?	☐	☐
If yes: do you wear a CPAP?	☐	☐
A sleep appliance?	☐	☐
Have you noticed or been told of any of the following while you are sleeping?		
Snoring, heavy or loud breathing?	☐	☐
Break or pause in breathing?	☐	☐
Gasp, choke, or struggle to breathe?	☐	☐
Restless or agitated sleep? Grinding teeth?	☐	☐
Abnormal head posture (hyper-extension, etc.)?	☐	☐
Have you noticed any of the following during the day?		
Difficulty waking?	☐	☐
Wake with headaches and/or sore teeth/jaw muscles?	☐	☐
Tired during day?	☐	☐
Teeth sensitive to cold?	☐	☐
Gum tissue recession?	☐	☐

Women Only:

Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you using a birth control method?	☐	☐

Patient Dental History

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Patient's Name: _____

Date of Birth: _____

Reason for this visit: _____

When was your last dental visit? _____ What was done then? _____

How often did you visit the dentist before then? _____

Previous dentist (name and location): _____

Have you had a complete series of dental films (x-rays) Taken? Yes No When? _____

Where? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Is your drinking water fluoridated? _____

	YES	NO
Is it important for you to keep your teeth?	☐	☐
Is it important to better the function of your teeth?	☐	☐
Does food frequently get caught between teeth?	☐	☐
Do your gums often bleed while brushing?	☐	☐
Have you noticed loosening of your teeth?	☐	☐
Have you injured your head, neck, or jaw?	☐	☐
Do you have difficulty eating or swallowing?	☐	☐
Do you have a dry mouth?	☐	☐
Have you had a change in your ability to taste foods?	☐	☐
Problems of the Jaw – Have you noticed:		
Clicking of the jaw?	☐	☐
Pain (Joint, ear, side of face)?	☐	☐
Difficulty opening or closing?	☐	☐
Difficulty chewing?	☐	☐
Oral habits: Do you:		
Clench or grind your teeth?	☐	☐
Bite your lips or cheek frequently?	☐	☐

	YES	NO
Have you had:		
Orthodontic treatment (braces)?	☐	☐
Oral surgery?	☐	☐
Gum treatment	☐	☐
Your bite adjusted?	☐	☐
A bite plane/guard or other appliance?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐

If you could change anything about your smile, what would you change? _____

_____

_____

If you had to rate your smile from 1-10 with 1 being the worst & 10 being best, what would you give yourself?

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____ _____

Signature of patient or parent if minor Date

_____ _____

Doctor's Signature Date

G2 South

5846 Blackshire Path, Inver Grove Heights, MN 55076

Notice of Privacy Practices Acknowledgement Form

Patient's Name: (First Name, Last Name):	Date of Birth:

I understand that as part of my care, G2 South creates and maintains health records that describe my health history, symptoms, examinations, test results, diagnosis, procedures, treatment, and plans for future care or treatment I may receive. I understand that health information collected and stored will be used for the following:

- To support my care and treatment at G2 South (treatment)
- For continued treatment among health professionals who are involved and contribute to my health care (treatment)
- For billing purposes including information regarding my diagnosis, treatment, and services rendered (payment)
- For insurance claim processing by a third-party payers for verification of services billed (payment)
- A tool for routine healthcare operations such as assessing quality improvement (healthcare operations)

I understand that the Notice of Privacy Practices from G2 South defines more information regarding the use and disclose of my protected health information as well as my rights to my health information. By signing this, I acknowledge that G2 South has offered me a copy of their Notice of Privacy Practices. I acknowledge and understand the rights that I have over my protected health information. I authorize the use and disclosure of my protected health information as specified in the Notice of Privacy Practices. I authorize the use and disclosures for treatment, payment, and healthcare operations purposes for G2 South.

I authorized G2 South to communicate regarding my treatments to the following individual(s):

_____

_____

I understand that I am ultimately responsible for all charges incurred for dentistry performed at G2 South office including balances left after insurance payment has been received.

I understand that G2 South communicates through text messaging about appointment reminders that contain patient specific information. I agree to the communication through text messaging unless I select the box below.

☐ I do not wish to receive text message communication for appointment reminders (Check to Opt Out)

This consent will continue forever unless I cancel it by writing to: G2 South, 5846 Blackshire Path, Inver Grove Heights, MN 55076; if the consent is cancelled, it will not change releases that have already been made prior to the date of cancellation. I don't want the consent to never expire, please expire the consent as of: _____.
I understand that I can get an electronic copy of the Notice of Privacy Practices at www.g2dental.com.

_____ _____

Patient's Signature/Legal Representative Signature Date (MM/DD/YYYY)

If Legal Representative, relationship to Patient (parent, guardian, ect) _____

Optional: Please e-mail me a copy of the Notice of Privacy Practices to the following e-mail address:
_____

Internal Use:

If patient refuses to sign, please have 2 staff members of G2 South Sign Below:

_____ _____

Staff's Signature Staff's Signature

Reason for Refusal of Signature: _____