Jay Gronemyer, DMD

1553 NW Canal Blvd., Ste. 101, Redmond, OR 97756

T: 541-923-2880 F: 541-923-2881

RedmondTeeth.com

Name: ______________________________ Birthdate: _______________

Address: ____

City, State, Zip____

Cell # ____________________ Home #________________ Email:______________________

SSN (for dental insurance purposes) ________________________

Dental Insurance: ____

Subscriber:______________________ **Relationship to Subscriber: Self Spouse Child**

ID# ______________________________ **Group #** ______________________

Subscriber Birthdate _______________**Subscriber's Employer**______________________

*How did you hear about our office? ___________________________________

DENTAL HISTORY

When was your last dental Check-up? __________ X-Rays __________Cleaning ________

Which type of toothbrush do you use? Manual ____ Electric _____

How often do you: Brush your teeth _________ Floss ________

Are your teeth sensitive to: Hot ___ Cold ____ Sweets ___ Chewing Pressure ___

Do your gums bleed after brushing / Are they often sore or tender? Y N

Do you get food caught between your teeth? Y N

Do you have difficulty swallowing, or chewing or do you frequently chew on one side: Y N

Do you clench or grind your teeth: Y N

Do you suffer from frequent headaches, earaches, stiffness or soreness in your neck? Y N

Do you notice popping, clicking or soreness in the jaws or just in front of the ears? Y N

Are you satisfied with the appearance of your teeth? Y N

In general do dental treatments cause you much concern or worry? Y N

Are you having any specific problems with your teeth, gums or mouth? Y N

If Yes, what? ____

Rate your smile from 1 to 10 (Circle one) 1 2 3 4 5 6 7 8 9 10

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MEDICAL HISTORY

Are you under a physician's care now? Y N Explain: ______________________

Physician's Name: ______________________

Any Allergies to the following? Penicillin Codeine Metal Latex Sulfa Local Anesthetic Aspirin
any OTHER allergies not listed? ______________________

Are you taking any Medications? Y N

Please List Any Medications: ______________________

Do have, or have you had, any of the following:

AIDS/HIV Positive	**Y N**	**Diabetes**	**Y N**	**Leukemia**	**Y N**
Alzheimer's Disease	**Y N**	**Drug Addiction**	**Y N**	**Liver Disease**	**Y N**
Anaphylaxis	**Y N**	**Emphysema**	**Y N**	**Low Blood Pressure**	**Y N**
Anemia	**Y N**	**Epilepsy/Seizures**	**Y N**	**Lung Disease**	**Y N**
Angina	**Y N**	**Excessive Bleeding**	**Y N**	**Mitral Valve Prolapse**	**Y N**
Arthritis	**Y N**	**Excessive Thirst**	**Y N**	**Pain in Jaw Joints**	**Y N**
Artificial Heart Valve	**Y N**	**Fainting/Dizziness**	**Y N**	**Psychiatric Care**	**Y N**
Artificial Joint	**Y N**	**Frequent Cough**	**Y N**	**Radiation Treatment**	**Y N**
Asthma	**Y N**	**Gout**	**Y N**	**Renal Dialysis**	**Y N**
Blood Disease	**Y N**	**Hay Fever**	**Y N**	**Rheumatic Fever**	**Y N**
Blood Transfusion	**Y N**	**Heart Attack/Failure**	**Y N**	**Rheumatism**	**Y N**
Breathing Problems	**Y N**	**Heart Murmur**	**Y N**	**Scarlet Fever**	**Y N**
Bruise Easily	**Y N**	**Heart Pace Maker**	**Y N**	**Sickle Cell Disease**	**Y N**
Cancer	**Y N**	**Heart Trouble/Disease**	**Y N**	**Sinus Trouble**	**Y N**
Chemotherapy	**Y N**	**Hemophilia**	**Y N**	**Stroke**	**Y N**
Chest Pains	**Y N**	**Hepatitis A B or C**	**Y N**	**Swelling of Limbs**	**Y N**
Cold Sores/Blisters	**Y N**	**High Blood Pressure**	**Y N**	**Thyroid Disease**	**Y N**
Congen. Heart Disorder	**Y N**	**Hypoglycemia**	**Y N**	**Tonsillitis**	**Y N**
Convulsions	**Y N**	**Irregular Heartbeat**	**Y N**	**Tumors/Growths**	**Y N**
Cortisone Medicine	**Y N**	**Kidney Problems**	**Y N**	**Tuberculosis**	**Y N**
Do you use Tobacco?	**Y N**	**Ulcers**	**Y N**		

Do you use controlled substances? ***Y N***

Women: *Are you Pregnant / Nursing? Y N*
Are you taking Oral Contraceptives? Y N

Have you ever had any serious illness not listed?

____

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Cancellation Policy

We recognize that your time is valuable, and our time is too. To respect the time of our team and other patients who need treatment, we require 48 hours to accommodate cancellations or rescheduling. Our office fee for short notice and no show appointments is $100. For some appointments a deposit may be required to reschedule. Thank you for your understanding.

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy describes the types of uses and disclosures of your protected health information that might occur in your treatment, payment for services or in the performance of office health care operation. The Notice of Privacy Practices also describes your rights and Dr. Jay Gronemyer, DMD's duties with respect to your protected health care information.

Dr. Jay Gronemyer, DMD is hereby authorized to release any medical or incidental information that may be necessary for medical care or in the processing of dental insurance.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby authorize disclosure of my protected health care information to the person indicated below.

______ Any member of my immediate family ______ Spouse only

I acknowledge that I have read the above statements and conditions and agree to the contents.

Signature ____

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FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we will help you to receive your maximum allowable benefits. In order to do this, we need your assistance and your understanding of our financial policy.

Payment for services are due at the time services are provided. If you have insurance please be prepared to pay your portion of the fee on the day of service. We accept cash, checks, most major credit cards, and Care Credit.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You MUST realize however, that:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Dental insurance is not meant to be a pay-all: it is only meant to be an aid. Many routine dental services are not covered by dental insurance at all. If you should have any questions regarding your coverage, please contact your company regarding the details of the plan it is conducting on your behalf.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of all insurance claims is a courtesy we extend to our patients, all charges are your responsibility.

If you have any questions about the above information or are uncertain regarding insurance information, PLEASE do not hesitate to ask us. We are here to help you.

"I understand and agree that regardless of my insurance, I am responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet."

Signature: ____

Printed Name: ____ Date:____________