PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Has any member of your family ever been treated in our office?
☐Yes ☐No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No

☐Payment in full at each appointment (cash or personal check)

☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)

Card # _____ Exp. Date _____

☐I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur or Defect *	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophilia	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Methemoglobinemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Aredia I.V. Reclast I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder*	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Swelling of Limbs	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Lung Disease	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Breathing Problem	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Shortness of Breath	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Frequent Cough	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt*	☐	☐	Hay Fever	☐	☐	Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis*	☐	☐	Bloody Sputum	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Emphysema	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Tuberculosis	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen?*	☐	☐
Anemia	☐	☐	Cancer	☐	☐	Protease Inhibitor	☐	☐				Cochlear implants?	☐	☐
Coronary Stent*	☐	☐	X-Ray Treatments (Radiation)	☐	☐									

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____
History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.

Smile Assessment

Name: _____ Date: _____

We find that many patients are not aware of the wide array of services we provide. To help you be aware of all that is possible in making you more comfortable and confident with your smile, we are pleased to offer this Smile Assessment to identify any areas of concern you might have.

1. Do you have chips or sharp edges on your teeth?	Yes	No
2. Are there spaces between your teeth that bother you?	Yes	No
3. Do you have dark-colored fillings that show when you smile?	Yes	No
4. Do you feel that your teeth are too long?	Yes	No
5. Do you feel that your teeth are too short?	Yes	No
6. Are your teeth crowded?	Yes	No
7. Do you avoid smiling when you have photos taken?	Yes	No
8. Has a family member or friend ever suggested you have work done on your teeth or smile?	Yes	No
9. Do you wish your teeth were shaped or proportioned differently?	Yes	No
10. Do you have missing teeth you would like to have replaced?	Yes	No
11. Do you think your smile reveals too much of your gums?	Yes	No
12. Do you have existing dental work that you feel is unsightly or that you are no longer satisfied with?	Yes	No
13. Do you wish your teeth were whiter or a more consistent shade or color?	Yes	No
14. Are you teeth tilted, unevenly angled or crooked?	Yes	No
15. PATIENTS WITH DENTURES OR PARTIALS. Are you unhappy with the fit, function and appearance of your denture(s) or partial(s)?	Yes	No

16. What would you change about your smile if you could? _____

_____

REAGAN GRIZZLE, D.D.S.
4501 SWEETWATER BLVD.
SUGAR LAND, TEXAS 77479
281-980-4104

APPOINTMENT CANCELLATION POLICY

YOUR APPOINTMENT IS RESERVED JUST FOR YOU. IF THERE IS A NEED TO CHANGE YOUR APPOINTMENT, PLEASE BE COURTEOUS AND CALL AHEAD SO THAT ANOTHER PARIENT CAN HAVE THE OPPORTUNITY TO BE SEEN.

OUR OFFICE REQUESTS A 48 HOUR COURTESY CALL FOR A CANCELLED APPOINTMENT. THE CHARGE FOR AN APPOINTMENT NOT CANCELLED IN THIS MANNNER IS $25 FOR THE FIRST 45 MINUTES AND $25 FOR EACH 15 MINUTES THEREAFTER.

THIS POLICY IS IN PLACE TO ENSURE THAT YOU CAN RECEIVE YOUR DENTAL CARE IN A TIMELY AND PROFESSIONAL MANNER. WE UNDERSTAND THAT EMERGENCIES AND UNFORSEEN CIRCUMSTANCES DO ARISE AND WILL MAKE ALLOWANCES FOR SUCH.

THANK YOU FOR YOUR CO-OPERATION.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE "APPOINTMENT CANCELLATION POLICY" OF DR. GRIZZLE.

_____ _____

PATIENT SIGNATURE DATE

Adjunctive Oral Cancer Screening Acceptance Form

Complete each time the exam is offered and place in the patient's file

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and screen for it in every patient.

Research has shown that late detection of oral cancer is the primary reason that mortality rates are so dismal.* As with most other cancers, age is the primary risk factor for oral cancer.* Tobacco use is also a major predisposing risk factor, however 1 in 4 who are diagnosed with oral cancer have no known risk factors.*

We find that using ViziLite TBlue - along with a visual oral cancer examination - improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life.* ViziLite TBlue is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage. The ViziLite TBlue exam will be offered to you annually.

Dental insurance may or may not cover the ViziLite TBlue exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form to use to file this procedure with your medical insurance. The fee for this exam is $ 65.00

Yes. I authorize the clinician to perform the ViziLite TBlue exam along with the standard oral cancer examination. I accept financial responsibility for this exam.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have the ViziLite TBlue exam at this time.

Print name: _____

Signature: _____ Date: _____

ViziLite® TBlue

because early detection may save lives

Oral cancer risks include:*

- Tobacco use
- Chronic alcohol consumption
- Oral HPV 16/18 infection

25% of oral cancers occur in people who don't smoke and have no other risk factors

Interested in learning more about oral cancer?

Scan the QR code to download an educational ebook on oral cancer.

* Data on file

ZILA

500 White Drive, Batesville, AR 72501 | 800.228.5595 | zila.com

650602 Rev 1 0313

REAGAN GRIZZLE, D.D.S.

HIPPA Consent Form

4501 Sweetwater Boulevard
Sugar Land, Texas 77479
Telephone: (281) 980-4104
Fax: (281) 980-9696

Patient Name: _____

HIPPA – Notice of Privacy Practice

HIPPA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Reagan Grizzle, D.D.S. may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPPA regulations.

Regan Grizzle, D.D.S. has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPPA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the Notice.

Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our HIPPA Compliance Officer listed below:

Reagan Grizzle, D.D.S.

(281) 980-4104

4501 Sweetwater Blvd

Sugar Land, Texas 7747

I hereby acknowledge that I have received a copy of Reagan Grizzle, D.D.S. Notice of Privacy Practices.

_____

Signature of Patient/Guardian Date

Permission to Share Medical Information

My medical information may be obtained and exchanged verbally to:

_____ _____

Relationship to Patient

_____

Insurance

Our Policy
Regarding Dental Insurance

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance".

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

In order for us to obtain you insurance information for submit your claim and/or discuss your situation directly with your insurance please complete the "Insurance Information Release Form" (attached) and return.

I have read and understand the above.

Print Patient Name _____ Patient Signature _____ Date _____

Reagan Grizzle, D.D.S.
4501 Sweetwater Blvd.
Sugar Land, TX 77479
(281) 980-4104