Rapid City Smiles

Implant & Family Dentistry Dr. Dan Graves, DMD

Patient Information

Name: _____ Date: _____

DOB: _____ Phone #: _____

Address: _____ City: _____

State: _____ Zip: _____ SS#: _____

Employer: _____ Email: _____

Emergency Contact: _____ Phone #: _____

Drives License # and state issued _____

Parent Information in case of minor:

First Name: _____ Last Name: _____

DOB: _____ SS#: _____

Date of last dental visit? _____ Name of previous Dentist? _____

Reason for today's visit: _____

Are there any medical conditions we should be aware of? Y / N

If yes: _____

Date of last medical exam: _____

Have you had a hip or joint replacement? Y / N

Do you require a pre-med prior to dental treatment? Y / N

How did you hear about our office? _____

Patient Health History

Please check if you have or have had any of the following.

Arthritis, Rheumatoid [Y][N]

Artificial Heart Valves [Y][N]

Artificial Joints [Y][N]

Asthma [Y][N]

Abnormal Bleeding [Y][N]

Blood Disorder [Y][N]

Cancer [Y][N]

Chemical Dependency [Y][N]

Chemotherapy [Y][N]

Cortisone Treatments [Y][N]

Covid-19 [Y][N]

Diabetes [Y][N]

Endocarditis [Y][N]

Epilepsy [Y][N]

Fainting or Dizziness [Y][N]

MEDICATIONS

List any medications here:

_____

_____

_____

_____

Glaucoma [Y][N]

Heart Murmur [Y][N]

Heart Disease [Y][N]

Type: _____

Hepatitis [Y][N]

Type:_____

High Blood Pressure [Y][N]

HIV Positive [Y][N]

Kidney Disease [Y][N]

Liver Disease [Y][N]

Mitral Valve Prolapse [Y][N]

MRSA [Y][N]

OSA [Y][N]

Pacemaker [Y][N]

Psychiatric Treatment [Y][N]

ALLERGIES

List any allergies here:

_____

_____

_____

_____

Radiation Treatment [Y][N]

Respiratory Disease [Y][N]

Rheumatic Fever [Y][N]

Shortness of Breath [Y][N]

Sinus Trouble [Y][N]

Stroke [Y][N]

Swollen Neck Glands [Y][N]

Thyroid Problems [Y][N]

Tuberculosis [Y][N]

Tumor or Growth on Head or Neck [Y][N]

Venereal Disease [Y][N]

Do you have any conditions not listed? [Y][N]

Please List:

_____

Women:

Are you pregnant? [Y][N]

Due Date: _____

Are you nursing? [Y][N]

PAYMENT ARRANGEMENT FORM

I agree that I am responsible for all services rendered to the patient and that payment is due and payable to the practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and myself.

I agree to pay all deductible and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on my primary coverage.) I understand that while the practices will file claims with my insurance company on my behalf, I remain responsible to pay the practice for what is not paid by my insurance company. I also understand that if the practice cannot verify insurance benefits eligibility for me prior to treatment, I will pay in full for services at the time they are rendered.

I understand that the practice may charge:

1) A late fee if payment on my account is not received by the due date.
2) An amount equal to $35, but not to exceed the max amount permitted by law for returned checks.
3) A $35 fee for each appointment that is missed/cancelled without at least 24 hours advanced notice.

I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney for collection purposes, to pay reasonable attorney fees and any expenses or costs related to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the practice.

Statements that are not paid in full after 90 days from the date of service will be turned over to our collection agency with an added $200 fee.

Responsible Party:

Full Name: _____ DOB: _____ SS#_____

Insurance Information:

Primary Insurance: _____ Subscribers name: _____

DOB: _____ SS#_____ Employer: _____

Ins. Co. Address: _____ Ins. Co. Phone #: _____

Group #:_____ ID/Member #:_____ Relation to Patient:_____

Secondary Insurance: _____ Subscribers name:_____

DOB:_____ SS#_____ Employer:_____

Ins. Co. Address: _____ Ins. Co. Phone #:_____

Group #:_____ ID/Member #:_____ Relation to Patient:_____

Rapid City Smiles Implant and Family Dentistry LLC
CONSENT AND ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We believe you have the right to know what we do with the health information we gather about you as a patient of Family Smiles Dental. We use and disclose health information about you for treatment, payment, and healthcare operations. We also want to assure you that we are properly safeguarding this important information. Because we value our relationship with our patients, we have prepared the following summary of our privacy policy, which is based on the federal law governing patient privacy and on our own high standards of patient confidentiality.

We need accurate, current health information about you so that we can determine your dental needs and recommend treatment to meet your specific needs. We collect personal information that you provide to us on registration forms and interviews. In addition, we may receive information from other health care providers authorized by you.

We will share your health information only with authorized employees, and other authorized healthcare professionals whose service may be required to assure the highest level of service to you. We may use or disclose your health information to provide you with appointment reminders such as voice mail, messages, postcards, or letters. We will not disclose any health information about you, except as authorized by you. By law reasonable belief that you are a victim of abuse, neglect, or domestic violence, as described in this privacy statement or as otherwise communicated to you.

You have the right to see and request (in writing) that we amend your health information. We may deny your request under certain circumstances. We will protect all information collected about you, and we will restrict access to your records by maintaining physical, electronic, and procedural safeguards.

If you have any questions or concerns about our privacy practices, please contact us. We support your right to the privacy of your health information.

All statements must be paid in full within 90 days of service. Failure to do so will result in your account being turned over to our collection agency with a $200.00 added fee.

Contact Officer: Dr. Dan Graves, DMD
Telephone: 605-716-7800
Address: 1801 Mt. Rushmore Road Rapid City, SD 57701

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practice. I understand that, by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Print Name: _____

Signature: _____ Date: _____

*You may refuse to sign this acknowledgement.
Is there someone you would like to authorize to have access to your records?

Name: _____ Contact Phone #: _____