Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name ______________________________ Soc. Sec.# ______________
Last Name First Name Initial

Address ______________ City ______________ State ______ Zip ______

Home Phone ______________ Cell Phone ______________ Email ______________

Sex ☐ M ☐ F Age______ Birthdate ______________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by ______________ Occupation ______________ Business Phone ______________

Business Address ______________ Business Email ______________

Whom may we thank for referring you? ______________

Notify in case of emergency ______________ Home Phone ______________

Cell Phone ______________ Business Phone ______________ Email ______________

Primary Insurance

Person Responsible for Account ______________________________ Soc. Sec.# ______________
Last Name First Name Initial

Birthdate ______________ Relation to Patient ______________

Address (if different from patient) ______________ City ______________ State ______ Zip ______

Home Phone ______________ Cell Phone ______________ Email ______________

Person Responsible Employed by ______________ Occupation ______________ Business Phone ______________

Business Address ______________ Business Email ______________

Insurance Company ______________ Contract # ______________ Group # ______________ Subscriber # ______________

Insurance Phone ______________ Insurance Email ______________

Name of other dependents under this plan ______________

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________________________ Soc. Sec. # ______________
Last Name First Name Initial

Birthdate ______________ Relation to Patient ______________

Address (if different from patient) ______________ City ______________ State ______ Zip ______

Home Phone ______________ Cell Phone ______________ Email ______________

Subscriber Employed by ______________ Business Phone ______________ Business Email ______________

Insurance Company ______________ Contract # ______________ Group # ______________ Subscriber # ______________

Insurance Phone ______________ Insurance Email ______________

Name of other dependents under this plan ______________

Please complete both sides.

Dental History

What would you like us to do today? ______________________ Are you in dental discomfort today? ________

Former Dentist ______________ Address ______________ Phone ________

Dentist's Email ______________________________

Date of last dental care ______________ Date of last X-rays ______________

Check Y for yes or N for no if you have/have not had the following:

☐Y ☐N Bad breath	☐Y ☐N Food collection between teeth	☐Y ☐N Periodontal treatment	☐Y ☐N Sensitivity to sweets
☐Y ☐N Bleeding gums	☐Y ☐N Grinding or clenching teeth	☐Y ☐N Sensitivity to cold	☐Y ☐N Sensitivity when biting
☐Y ☐N Clicking or popping jaw	☐Y ☐N Loose teeth or broken fillings	☐Y ☐N Sensitivity to hot	☐Y ☐N Sores or growths in mouth

How often do you brush? ________ How often do you floss? ________

How do you feel about the appearance of your teeth? ______________________________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Medical History

Physician's name ______________ Address ______________ Phone ________

Physician's Email ______________________________

Date of last visit ________ Have you had any serious illnesses or operations? ☐Y ☐N If yes, describe ______________

Are you currently under physician care? ☐Y ☐N If yes, describe ______________

Have you ever had a blood transfusion? ☐Y ☐N If yes, give approximate dates ______________

Have you ever taken Fen-Phen/Redux? ☐Y ☐N

Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills? ☐Y ☐N

Check (✓) whether you have had or currently have any of the following:

☐Y ☐N AIDS/HIV Positive	☐Y ☐N Cortisone treatments	☐Y ☐N Hepatitis	☐Y ☐N Seizures
☐Y ☐N Alcohol/Drug Abuse	☐Y ☐N Cough, persistent	☐Y ☐N High blood pressure	☐Y ☐N Shingles
☐Y ☐N Anaphylaxis	☐Y ☐N Cough up blood	☐Y ☐N Jaw pain	☐Y ☐N Shortness of breath
☐Y ☐N Anemia	☐Y ☐N Diabetes	☐Y ☐N Kidney disease or malfunction	☐Y ☐N Skin rash
☐Y ☐N Arthritis, Rheumatism	☐Y ☐N Epilepsy		☐Y ☐N Spina bifida
☐Y ☐N Artificial heart valves	☐Y ☐N Fainting	☐Y ☐N Liver disease	☐Y ☐N Stroke
☐Y ☐N Artificial joints	☐Y ☐N Food allergies	☐Y ☐N Material allergies (**latex**, wool, metal, chemicals)	☐Y ☐N Surgical implant
☐Y ☐N Asthma	☐Y ☐N Glaucoma		☐Y ☐N Swelling of feet or ankles
☐Y ☐N Atopic (allergy prone)	☐Y ☐N Headaches	☐Y ☐N Mitral valve prolapse	☐Y ☐N Thyroid disease or malfunction
☐Y ☐N Back problems	☐Y ☐N Heart murmur	☐Y ☐N Nervous problems	
☐Y ☐N Blood disease	☐Y ☐N Heart problems Describe ________	☐Y ☐N Pacemaker/Heart surgery	☐Y ☐N Tobacco habit
☐Y ☐N Cancer		☐Y ☐N Psychiatric care	☐Y ☐N Tonsillitis
☐Y ☐N Chemical dependency	☐Y ☐N Hemophilia/ Abnormal Bleeding	☐Y ☐N Rapid weight gain or loss	☐Y ☐N Tuberculosis
☐Y ☐N Cholesterol problems		☐Y ☐N Radiation treatment	☐Y ☐N Ulcer/Colitis
☐Y ☐N Chemotherapy	☐Y ☐N Hereditary Problems	☐Y ☐N Respiratory disease	☐Y ☐N Venereal disease
☐Y ☐N Circulatory problems	☐Y ☐N Herpes	☐Y ☐N Rheumatic/Scarlet fever	

List medications you are currently taking, if any: ______________________________

List drug allergies, if any: ______________________________

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________________ Date ______________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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NOTICE OF PRIVACY PRACTICES

Grout Family Dentistry, P.C. **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. You have the right to obtain a paper copy of this Notice upon request.**

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: *Required by Law:* We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. *Research*: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-elated injuries or illness.
In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person If you have any questions, requests, or complaints, please contact:

Ronald W. Grout, DDS
Jeffery B. Grout, DDS
Grout Family Dentistry, P.C.
8 West Dry Creek Cr., Suite 101
Littleton, CO 80120
303-730-1222

Effective Date: April 14, 2003

I, ______________________________,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:____________________Date:______

If not signed, reason why acknowledgement was not obtained: ____________________

Staff Witness seeking acknowledgement

________________________Date: _______

RONALD W. GROUT, DDS
JEFFREY B. GROUT, DDS

Members: American Dental Association, Colorado Dental Association, Arapahoe County Dental Society, Metro Denver Dental Society

Voluntary Services: St. Andrew United Methodist Church, Family Promise, American Red Cross, 9 Health Fair, Denver Rescue Mission "Give Kids a Smile Day" (CDA)

COMPREHENSIVE DENTISTRY:

- Thorough exams
- In office & at home whitening
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- Porcelain veneers
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- Dental implant restorations
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- Gentle ultrasonic cleanings
- TMJ diagnosis & treatment
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- On time appointments & care
- Early morning & lunchtime appointments
- Insurance accepted & filed for you
- Interest free payment plans
- After-hours care for emergencies
- Ample free & convenient parking
- Easy access for disabled patients (street level entry)

Phone: 303-730-1222
Fax: 303-730-2096
8 West Dry Creek Circle
Suite 101
Littleton, CO 80120
Visit:
GroutFamilyDentistry.com

GROUT FAMILY DENTISTRY
Masters in adult & family dentistry

REQUEST FOR COPY OF PATIENT RECORDS

To: ______________________________

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I, hereby designate Dr. Ronald Grout, DDS and/or Dr. Jeffrey Grout, DDS, as my designated representative to receive copies of my patient records, including x-rays, and authorize and direct you to provide copies of my patient records to them.

Please forward copies of my complete patient file, including x-rays, to:

Ronald W. Grout, DDS
Jeffrey B. Grout, DDS
8 West Dry Creek Circle
Suite #101
Littleton, CO 80120

Email address: info@groutfamilydentistry.com

If you have questions, please contact our office at (303) 730-1222.

____
Patient (Please print full name)

______________________________ **Date:** __________
Signature of Patient (Parent of Legal Guardian if patient is a minor)