Patient information

Updated December 30, 2020

Patient information

Today's date: _____

Last name: _____ First Name: _____

Preferred name: _____ Sex: ☐ M ☐ F

Marital status: _____ Birthdate: _____

Social security number: _____

Address: _____ City: _____

_____ State: _____ Zip code: _____

Who can we thank for referring you? _____

Your occupation: _____ Email address: _____

Home phone: _____ Work phone: _____

Mobile phone: _____

What kind of appointment reminders do you prefer? (check all that apply)

☐ Email ☐ Text message ☐ Phone call

Person responsible for account

☐ Same as above

Name: _____ Relationship: _____

Social security number: _____ Date of birth: _____

☐ Same as above

Address: _____ City: _____

_____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____

Mobile phone: _____

Continued on reverse

Chad Stevenson D.D.S.
Andrew Stevenson D.D.S.
Jori May D.D.S.

515-223-1940
ContactUs@Grand.Dental

1005 Grand Avenue, Suite 200
West Des Moines, Iowa 50265

Patient information

Updated December 30, 2020

Dental (insurance) benefits information

☐ I do not have dental benefits

☐ I have my benefits card *(If you give it to us, you can skip to the next section)*

Primary benefits carrier name: _____

Group plan name: _____ Group number: _____

Member ID or social security number: _____

Benefits company phone: _____ Employer: _____

☐ I have secondary insurance benefits.

☐ This policy is held by someone other than myself (please fill out below)

Subscribers name: _____ Subscribers relationship to patient: _____

Subscriber member number: _____ Subscribers social security number: _____

Subscribers date of birth: _____

Assignment & release

I understand that I am financially responsible for all charges regardless of benefits or any other third party involvement. At Grand Dental we strive to provide accurate estimates of your out-of-pocket costs. These estimates are our best guess, given the limited information that we have about your benefits. Ultimately, we are a third party filing your benefit on your behalf, as a courtesy to you.

I certify that I, and/or my dependent(s), have dental benefit coverage as stated above and assign directly to Chad B. Stevenson D.D.S., P.C., doing business as Grand Dental, all benefits, if any, for services rendered. I authorize the use of my signature on all submissions. Grand Dental may use my healthcare information and may disclose such information to the above-named dental benefit company(ies) and their agents for the purpose of obtaining payment for services and determining dental benefits or the benefits payable for related services.

Sign here Signature: _____ Date: _____

Your health history

About you

Name: _____

Date of birth: _____ Today's date: _____

Dental History

Approximate date of last dental visit: _____ Approximate date of last x-rays: _____

Allergies

Are you allergic to any medicines, metals, foods, or environmental allergens? ◯ **Yes** **No** ◯
If yes, to what? _____

Medical history

Yes	*No*	
◯	◯	Have you been hospitalized in the past two years?
◯	◯	Are you currently being treated by a physician?
◯	◯	Do you have any undiagnosed symptoms?
◯	◯	Have you received counseling for alcohol or other drug use?
◯	◯	Do you bleed excessively upon injury?
◯	◯	Do you use tobacco products?
◯	◯	Have you ever injured your jaws or teeth?
◯	◯	Are you currently pregnant?
◯	◯	Do you use birth control drugs?
◯	◯	Have you ever undergone osteoporosis or bisphosphonate therapy?
◯	◯	Has a doctor ever told you that you have a heart problem?
◯	◯	Do you ever have difficulty breathing?
◯	◯	Do your gums bleed when you brush your teeth?

Continued on reverse

Chad Stevenson D.D.S.
Andrew Stevenson D.D.S.
Jori May D.D.S.

515-223-1940
ContactUs@Grand.Dental

1005 Grand Avenue, Suite 200
West Des Moines, Iowa 50265

Your health history

Name: _____

Please mark all conditions that you have previously or currently experience:

- ☐ Heart attack
- ☐ Stroke
- ☐ Rheumatic fever
- ☐ Artificial heart valve
- ☐ Pacemaker placement
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Thyroid problems
- ☐ Hepatitis
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Tuberculosis
- ☐ Epilepsy/seizures
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Other: _____
- ☐ Joint replacement
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Sexually transmitted infection
- ☐ Psychiatric therapy
- ☐ Asthma
- ☐ Osteoporosis
- ☐ Cancer

Medications

Please list all medications that you take regularly, both prescription and over-the-counter.

_____

_____

_____

_____

Healthcare providers

Please list your primary care provider as well as any specialists that you see at least once each year.

_____

_____

_____

Emergency contact

Who should we contact in case of an emergency? _____

Phone: _____ Relationship: _____

Chad Stevenson D.D.S.
Andrew Stevenson D.D.S.
Jori May D.D.S.

515-223-1940
ContactUs@Grand.Dental

1005 Grand Avenue, Suite 200
West Des Moines, Iowa 50265

GRAND.DENTAL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 15, 2003, and will remain in effect until we replace it.
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.
You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Over please.

Chad Stevenson D.D.S.
Andrew Stevenson D.D.S.
Jori May D.D.S.

515-223-1940
ContactUs@Grand.Dental

1005 Grand Avenue, Suite 200
West Des Moines, Iowa 50265

GRAND.DENTAL

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $10 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Chad Stevenson DDS
Telephone: 515-223-1940 Fax: 515-223-1062
E-mail: BusinessOffice@Grand.Dental
Address: 1005 Grand Avenue Suite 200 West Des Moines, IA 50265

I received notice of and acknowledge these privacy practices as the relate to my protected healthcare information and treatment.

Signature **Date**

Printed name

☐ Self
☐ Parent/guardian
☐ Power of attorney

Chad Stevenson D.D.S.
Andrew Stevenson D.D.S.
Jori May D.D.S.

515-223-1940
ContactUs@Grand.Dental

1005 Grand Avenue, Suite 200
West Des Moines, Iowa 50265

GRAND.DENTAL

Request for patient information

Dear _____,

We share a mutual patient, _____,

date of birth _____, who has an upcoming appointment at our office. We would appreciate your help in acquiring this patient's current pantomograph and bitewing radiographs. While our office would prefer digital images, we can receive them by whatever medium and mode is most suitable to your office.

Address	Email	Fax
1005 Grand Avenue Suite 200 West Des Moines, IA 50265	ContactUs@Grand.Dental	515-223-1062

Patient release

I confirm that I am the individual listed below and have the legal authority to initiate a transfer of records containing protected health information for the individual listed above. I authorize the aforementioned provider to release the requested protected health information and send it Grand Dental in a manner consistent with the Health Insurance Portability & Accountability Act of 2006.

_____

Printed name

_____ _____

Signature Date

Relationship: ☐ Self ☐ Parent or legal guardian ☐ Medical power of attorney