



## *What to expect at your first visit*

Dr. Mundy-Burgett strives to make Grin Dentistry the most comfortable experience you have ever had in a dental practice.

One cornerstone of this comfort experience is providing a thorough and comprehensive initial consultation.

Since all patients and their dental needs are unique, we start with this comprehensive approach with all patients so we can formulate a tailored plan for you together.

The typical initial visit consists of the following:

- Meeting a treatment coordinator and receiving a tour of our office
- Review of new patient forms
- Review of primary dental concerns and past dental history
- Review of past medical history as certain health conditions have significant bearing on your dental care
- Digital x-rays of teeth obtained [as x-rays outside of six months are too old for treatment planning]
- Laser detection of caries ("cavities")
- Tooth-by-tooth examination with a small tooth-brush size video camera
- Oral cancer screening examination aided with the new technology VELscope
- Periodontal examination for gum disease
- Discussion of dental needs and wants to create a personal plan to improve your dental health and smile

Many patients desire a dental cleaning at the time of their initial visit.

We try to provide this service whenever possible; however, some factors such as medical history or the nature of the cleaning that is required can prevent routine cleaning being performed on the first visit.



New Patient Information

Personal Information

Today's date
First name Middle initial Last name
I prefer to be called Male Female
Address City State ZIP
Date of Birth Social Security #
Cell Phone Work Phone Home Phone
Primary contact number (please check one) Cell Work Home
Email Employer
Spouse's name Spouse's employer
Whom may we thank for referring you?
Are you currently a student? School Grade/Year
Emergency contact person/ contact number

Dental Information

Reason for today's visit
Are you currently in pain? Yes No
If so, please describe
Do you have any dental problems right now? Yes No
If so, please describe
Have you ever had trouble with previous dental treatment? Yes No
If so, please describe
Anything we can do to improve upon your past dental treatments?
Please rate your level of anxiety about seeing the dentist (least) 1 2 3 4 5 (most)
Have you used nitrous oxide (laughing gas) for past treatment? Yes No
If not, would you be interested in trying nitrous oxide when having dental treatment completed? Yes No
Are you interested in hearing about Sedation dentistry? Yes No



New Patient Information

Approximate Date of last cleaning \_\_\_\_\_

Procedure(s) done at last dental visit \_\_\_\_\_

Are you looking for a change in the way your smile looks?  Yes  No

If you could change anything about your teeth, it would be (check all that apply)

- Color of your teeth  Too much or too little of teeth show when you smile
 Size/Shape of your teeth  Too much or too little gum shows when you smile
 Gaps between your teeth  Alignment of your teeth
 Other \_\_\_\_\_

Do you have? (check all that apply)

- Sensitive or receding gums  Worn/broken/chipped teeth
 Missing teeth  Old crowns that have dark edges at the top
 Teeth sensitive to heat/cold  Teeth sensitive while chewing
 Concerns about bad breath  Old or discolored fillings
 Other \_\_\_\_\_

Have you ever experienced ? (check all that apply)

- Periodontal disease/gum treatment  Yes  No Discomfort in you jaw point (TMJ/TMD)  Yes  No
Orthodontics treatment  Yes  No Your bite adjusted or balanced  Yes  No
Oral surgery/ Wisdom Teeth  Yes  No Serious injury to the mouth or head  Yes  No
A bite plate or mouth guard  Yes  No Chronic bad breath  Yes  No
Snoring  Yes  No Grinding of teeth (day or night)  Yes  No

If yes to any of the previous questions, please describe \_\_\_\_\_

Do you require antibiotics before dental treatment?  Yes  No If yes, why? \_\_\_\_\_

Have you ever taken, currently take, or plan to take medication for osteoporosis? (Bisphosphonates)  Yes  No

Is there anything else about your past dental treatment(s) that you would like us to know? \_\_\_\_\_



Dental Insurance

Primary Carrier:

Insurance co. name \_\_\_\_\_ Insured's I.D. no. \_\_\_\_\_
Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_
Date of birth of Insured \_\_\_\_\_ Insured's employer name \_\_\_\_\_

Secondary Carrier:

Insurance co. name \_\_\_\_\_ Insured's I.D. no. \_\_\_\_\_
Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_
Insured's date of birth \_\_\_\_\_ Insured's employer name \_\_\_\_\_

If the patient is a minor:

Name of parent or legal guardian and relationship \_\_\_\_\_

Is this parent or legal guardian currently a patient in our office? [ ] Yes [ ] No

Office and Financial Policy

Our mission is to deliver the finest, most cost-effective health care treatment available today. Following diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the investment in today's and future treatment.

Payment is due at the time services are rendered. For your convenience we accept cash, personal check, Visa, MasterCard, Discover and American Express. We also offer convenient payment options through CareCredit.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies may not pay for all your costs. Your insurance policy is a contract between you and your insurer.

As a courtesy we will be glad to file your claim for you provided we have complete and accurate insurance information. You will be expected to pay for services rendered if the office is unable to verify your insurance information prior to treatment. If payment for services already rendered has not been paid within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible. Should additional means of collection become necessary, all costs of collection, including attorney fees, court costs and collection agency fees (35% standard collection/50% legal collection) will be added to your existing balance. Your cooperation with this policy will assure equitable treatment of insured and non-insured patients.

We reserve the right to charge and collect fees for broken appointments. Appointments are reserved exclusively for you. We consider an appointment confirmed once the appointment is scheduled. A minimum charge of \$45 per hour may be posted to your account if an appointment is cancelled without a 48 hour advance notice. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Any accounts overdue for patient payment in excess of 45 days are subject to an interest fee of 18% per annum. A returned check fee of \$35 will be added to your account balance for any checks returned to us as non-sufficient funds (NSF).

Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment.

I, the undersigned, authorize payment of the dental benefits otherwise payable to me, directly to Grin Dentistry.

I have read and understand this financial policy.

PRINTED NAME

SIGNATURE

DATE



Photography Release

I \_\_\_\_\_, hereby authorize Dr. Malinda Mundy-Burgett to take photographs, slides and or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature

Date

Acknowledgement of Receipt of Notice of Privacy Practices

\*\*You May Refuse to Sign This Acknowledgement\*\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but, acknowledgement could not be obtained because:

- Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgment
Other (Please Specify)

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you

Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs
- Other If yes, please explain: \_\_\_\_\_

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

- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine        | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia            | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments       | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease       | <input type="radio"/> Yes <input type="radio"/> No | Diabetes                  | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A           | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss         | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis               | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction            | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C      | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis             | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia                    | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded             | <input type="radio"/> Yes <input type="radio"/> No | Herpes                | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever            | <input type="radio"/> Yes <input type="radio"/> No |
| Angina                    | <input type="radio"/> Yes <input type="radio"/> No | Emphysema                 | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure   | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism                 | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout            | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures      | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol      | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever              | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve    | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding        | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash         | <input type="radio"/> Yes <input type="radio"/> No | Shingles                   | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint          | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst          | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia          | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease        | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma                    | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat   | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble              | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease             | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough            | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems       | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida               | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea         | <input type="radio"/> Yes <input type="radio"/> No | Leukemia              | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches        | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease         | <input type="radio"/> Yes <input type="radio"/> No | Stroke                     | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily             | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes            | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure    | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs          | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer                    | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma                  | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease          | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease            | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy              | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever                 | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis                | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains               | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure      | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis          | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis               | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur              | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints    | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths          | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker           | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease   | <input type="radio"/> Yes <input type="radio"/> No | Ulcers                     | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions               | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease     | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care      | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease           | <input type="radio"/> Yes <input type="radio"/> No |
|                           |  |                           |  |                       |  | Yellow Jaundice            | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_