Adult Patient Registration Information

First Name _____ MI: ____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Patient SSN: _____ Marital status: ☐ Single ☐ Married

Responsible Party: ☐ Self ☐ Other _____

Contact Information

Patient Address: ☐ Own ☐ Other _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ ☐ Home ☐ Mobile ☐ Work

Phone number: _____ ☐ Home ☐ Mobile ☐ Work

Phone number: _____ ☐ Home ☐ Mobile ☐ Work

Email: _____ OK to email? ☐ Yes ☐ No

Occupation: _____

Employer: _____

We are a two doctor practice. Most of our patients see both Dr. McDonald & Dr. Gruchalla for their dental care. It is important to us that you and you family see the doctor you request.
Requests can change at any time- just let our office know!

I would like to see:
☐ Both Doctors ☐ Dr. McDonald only ☐ Dr Gruchalla only

☐ prefer Dr. McDonald, but Dr Gruchalla is OK if he is out of the office

☐ prefer Dr. Gruchalla, but Dr. McDonald is OK if she is out of the office

Do you have a preference which hygienist you see? _____

10/06/2022

Medical History Form

Patient Name:

Date of Birth:

Sex:

Emergency Contact _____

Emergency Contact Phone _____

Emergency Contact Relationship _____

Do you have any of the following diseases or problems

Active Tuberculosis ..... ○ Yes ○ No

Persistent cough greater than a 3 week duration ..... ○ Yes ○ No

Cough that produces blood ..... ○ Yes ○ No

Been exposed to anyone with tuberculosis ..... ○ Yes ○ No

Medical History

Are you now under the care of a physician? ..... ○ Yes ○ No

Physician Name _____

Phone (including area code) _____

Address/City/State/Zip _____

Are you in good health? ..... ○ Yes ○ No

Has there been any change in your general health within the past year? ..... ○ Yes ○ No

If yes, what condition is being treated? _____

Date of last physical exam _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ..... ○ Yes ○ No

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ..... ○ Yes ○ No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

_____

Do you wear contact lenses? ..... ○ Yes ○ No

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? ..... ○ Yes ○ No

Date _____

If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ○ Yes ○ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ○ Yes ○ No

Date Treatment began _____

Do you use controlled substances (drugs)? ..... ○ Yes ○ No

Do you use tobacco (smoking, snuff, chew, bidis)? ..... ○ Yes ○ No

If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____

Do you drink alcoholic beverages? ..... ○ Yes ○ No

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY. Are you:

Pregnant ..... ○ Yes ○ No

Number of weeks _____

Taking birth control pills or hormonal replacement? ..... ○ Yes ○ No

Nursing? ..... ○ Yes ○ No

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics	○ Yes	○ No	Latex (rubber)	○ Yes	○ No
Aspirin	○ Yes	○ No	Iodine	○ Yes	○ No
Penicillin or other antibiotics	○ Yes	○ No	Hay fever/seasonal	○ Yes	○ No
Barbiturates, sedatives, or sleeping pills	○ Yes	○ No	Animals	○ Yes	○ No
Sulfa drugs	○ Yes	○ No	Food	○ Yes	○ No
Codeine or other narcotics	○ Yes	○ No	Other	○ Yes	○ No
Metals	○ Yes	○ No	If Other, please specify: _____		

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve	○ Yes	○ No	Congenital heart disease (CHD)	○ Yes	○ No
Previous infective endocarditis	○ Yes	○ No	Unrepaired, cyanotic CHD	○ Yes	○ No
Damaged valves in transplanted heart	○ Yes	○ No	Repaired (completely) in the last 6 months	○ Yes	○ No
			Repaired CHD with residual defects	○ Yes	○ No

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease	○ Yes	○ No	Heart attack	○ Yes	○ No
Angina	○ Yes	○ No	Heart murmur	○ Yes	○ No
Arteriosclerosis	○ Yes	○ No	Low blood pressure	○ Yes	○ No
Congestive heart failure	○ Yes	○ No	High blood pressure	○ Yes	○ No
Damaged heart valves	○ Yes	○ No	Other congenital heart defects	○ Yes	○ No

Mitral valve prolapse ..... Yes No

Pacemaker ..... Yes No

Rheumatic fever ..... Yes No

Rheumatic heart disease ..... Yes No

Abnormal bleeding ..... Yes No

Anemia ..... Yes No

Blood transfusion ..... Yes No

If yes, date _____

Hemophilia ..... Yes No

AIDS or HIV ..... Yes No

Arthritis ..... Yes No

Autoimmune disease ..... Yes No

Rheumatoid arthritis ..... Yes No

Systemic lupus erythematosus ..... Yes No

Asthma ..... Yes No

Bronchitis ..... Yes No

Emphysema ..... Yes No

Sinus trouble ..... Yes No

Tuberculosis ..... Yes No

Cancer/Chemotherapy/Radiation Treatment Yes No

Chest pain upon exertion ..... Yes No

Chronic pain ..... Yes No

Diabetes Type I or II ..... Yes No

Eating disorder ..... Yes No

Malnutrition ..... Yes No

Gastrointestinal disease ..... Yes No

G.E. Reflux/persistent heartburn ..... Yes No

Thyroid problems ..... Yes No

Stroke ..... Yes No

Glaucoma ..... Yes No

Hepatitis, jaundice or liver disease ..... Yes No

Epilepsy ..... Yes No

Fainting spells or seizures ..... Yes No

Neurological disorders ..... Yes No

If yes, please specify _____

Sleep disorder ..... Yes No

Mental health disorders ..... Yes No

Specify _____

Recurrent infections ..... Yes No

Type of infection _____

Kidney problems ..... Yes No

Night sweats ..... Yes No

Osteoporosis ..... Yes No

Persistent swollen glands in neck ..... Yes No

Severe headaches/migraines ..... Yes No

Severe or rapid weight loss ..... Yes No

Sexually transmitted disease ..... Yes No

Excessive urination ..... Yes No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ..... Yes No

Name of physician or dentist making recommendation (include phone number) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No

Please explain _____

_____

Signature of Patient/Legal Guardian

Adult New Patient Dental History:

Previous Dentist: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date of last appointment: _____

How did you learn about our office? _____

Why have you come to the dentist today? _____

Are you currently in pain? _____

Have you ever had problems associated with dental work?

_____

Is there anything you would like to improve about your smile?

_____

Do you feel your current dental health is? ☐ Good ☐ Fair ☐ Poor
Do you use fluoridated toothpaste? ☐ yes ☐ no
Do your gums ever bleed? ☐ yes ☐ no
Have you ever been told you have periodontal disease? ☐ yes ☐ no
Have you ever seen a periodontist? ☐ yes ☐ no
Have you had braces? ☐ yes ☐ no
Have you had a dental appliance (night splint, retainer, snore guard, etc)? ☐ yes ☐ no
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD) or head and neck muscles? ☐ yes ☐ no
Have you had your wisdom teeth extracted? ☐ yes ☐ no
Do you get adequate rest at night (6-8 hours)? ☐ yes ☐ no
Do you feel sleepy during the day? ☐ yes ☐ no
Do you snore, clench, grind your teeth? ☐ yes ☐ no _____

Is there anything else we should know about your mouth?

_____

MCDONALD & GRUCHALLA DDS
DENTISTRY
James L. McDonald, DDS
Stephanie Guy Gruchalla, DDS

Thank you for choosing McDonald & Gruchalla, DDS as your dental home. We are grateful that you are entrusting your care to us! Please understand that payment of your account is considered part of the treatment experience and the following is a statement of our Financial Policy.

FINANCIAL POLICY

We believe that it is our responsibility to use our professional knowledge, skills, and judgment in helping you achieve your dental health goals. The fees for our services are based on the time procedures take and the materials used. It is up to you to make financial arrangements with our practice to pay for these services.

We accept the following forms of payment - Cash, Check, Visa, Mastercard & Discover. We offer a COURTESY discount on treatment paid in FULL on the day of service if the account is at a zero balance.

- 5% CASH OR CHECK
- 3% PLASTIC (credit or debit)

If you have dental insurance we will assist you with receiving the benefits available under your specific policy. The insurance policy is an agreement between YOU and your insurance company. Insurance benefits are determined by your employer and not your dentist. Insurance will often not pay for all your treatment needs. You are responsible for the final bill.

As a courtesy, we will happily file your insurance claim the day of service if you bring: 1.)Dental Insurance Card, and 2.)Employer Information. If you are unable to verify insurance coverage, you will be expected to pay the day of your appointment for services rendered. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectable. Insurance Co-pays & Deductibles are due at the time of your service. Co-payments are estimates, you are responsible for the balance remaining after insurance payments.

RESERVATION POLICY

Appointments are reserved exclusively for you in our schedule. We reserve the right to charge and collect fees for broken appointments -appointments that are canceled or broken without 24-hours advance notice. If proper notice is not received, a fee of $50 - $100 will be charged for your allotted time and the charge will be reflected on your statement.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a simple phone call. Please feel free to contact our staff at any time to discuss any concerns that you may have.

Thank you for understanding our Financial & Reservation Policy.

I have read and agree to the Financial Policy and the Reservation Policy of McDonald & Gruchalla, DDS.

Signature: _____

Statement of Privacy Policy

NOTICE OF PRIVACY PRACTICES

We are required under federal law to inform you of your rights to privacy provided by the HIPPA program, which became law April 14th, 2003.

We are required by federal and state law to maintain the privacy of your health information. We may use or disclose your health information during treatment, to obtain payment and in connection with health care operations.

We will not use your health information for marketing communications without your consent. You have the right to obtain copies of your health information upon written request and there will be a fee charged to you.

You have the right to request that we amend your health information upon written request. A more complete statement of Notice of Privacy Practices is available upon request.

McDonald & Gruchalla, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICESYou may refuse to Sign this Acknowledgement

Signature: _____

MCDONALD & GRUCHALLA DDS

DENTISTRY

James L. McDonald, DDS

Stephanie Guy Gruchalla, DDS

Patient Name:_____

(Print Name)

Date of Birth:_____

I hereby authorize the release of my dental records to my new office listed below:

McDonald and Gruchalla, DDS

1231 27th St SW

Fargo, ND 58103

Email: info@mgdentist.com or office@mgdentist.com

Sign:_____ Date:_____

1231 27th St. SW, Fargo, North Dakota 58103-2363

(Office) 701-235-1261 (Fax) 701-235-1268

mgdentist.com