

Child Patient Registration Information

First Name _____ MI: _____ Last Name: _____

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

Patient SSN: _____

Responsible Party: _____

Contact Information

Patient Address: Own Other _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Please list the phone number and email address you would like to be listed as the primary contact on your child's account:

Phone number: _____

Mother's Father's Other

Home Mobile Work OK to text? Yes No

Primary Email: _____

Mother's Father's Other

OK to email? Yes No

Parent's Marital status: Single Married Divorced Other _____

Mothers name: _____

Mother's Address: Same as child's Own Other _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Home Mobile Work OK to text? Yes No

Phone number: _____ Home Mobile Work OK to text? Yes No

Phone number: _____ Home Mobile Work OK to text? Yes No

Email: _____ OK to email? Yes No

Email: _____ OK to email? Yes No

Occupation: _____

Employer: _____

Fathers name: _____

Father's Address: Same as child's Own Other _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Home Mobile Work OK to text? Yes No

Phone number: _____ Home Mobile Work OK to text? Yes No

Phone number: _____ Home Mobile Work OK to text? Yes No

Email: _____ OK to email? Yes No

Email: _____ OK to email? Yes No

Occupation: _____

Employer: _____

Other adults who will bring child to appointments and can make treatment decisions:

Name / relationship: _____

Name / relationship: _____

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? _____

Pharmacy: _____

Physician: _____

Emergency Contact: _____ Phone Number: _____

Child 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 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 suck your thumb/fingers? 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?

Medical History Form

Patient Name:	Emergency Contact	_____
Date of Birth:	Emergency Contact Phone	_____
Sex:	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 <input type="radio"/> Yes <input type="radio"/> No | Latex (rubber) <input type="radio"/> Yes <input type="radio"/> No |
| Aspirin <input type="radio"/> Yes <input type="radio"/> No | Iodine <input type="radio"/> Yes <input type="radio"/> No |
| Penicillin or other antibiotics <input type="radio"/> Yes <input type="radio"/> No | Hay fever/seasonal <input type="radio"/> Yes <input type="radio"/> No |
| Barbiturates, sedatives, or sleeping pills <input type="radio"/> Yes <input type="radio"/> No | Animals <input type="radio"/> Yes <input type="radio"/> No |
| Sulfa drugs <input type="radio"/> Yes <input type="radio"/> No | Food <input type="radio"/> Yes <input type="radio"/> No |
| Codeine or other narcotics <input type="radio"/> Yes <input type="radio"/> No | Other <input type="radio"/> Yes <input type="radio"/> No |
| Metals <input type="radio"/> Yes <input type="radio"/> 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 <input type="radio"/> Yes <input type="radio"/> No | Congenital heart disease (CHD) <input type="radio"/> Yes <input type="radio"/> No |
| Previous infective endocarditis <input type="radio"/> Yes <input type="radio"/> No | Unrepaired, cyanotic CHD <input type="radio"/> Yes <input type="radio"/> No |
| Damaged valves in transplanted heart <input type="radio"/> Yes <input type="radio"/> No | Repaired (completely) in the last 6 months <input type="radio"/> Yes <input type="radio"/> No |
| | Repaired CHD with residual defects <input type="radio"/> Yes <input type="radio"/> No |

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

- | | |
|---|---|
| Cardiovascular disease <input type="radio"/> Yes <input type="radio"/> No | Heart attack <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Heart murmur <input type="radio"/> Yes <input type="radio"/> No |
| Arteriosclerosis <input type="radio"/> Yes <input type="radio"/> No | Low blood pressure <input type="radio"/> Yes <input type="radio"/> No |
| Congestive heart failure <input type="radio"/> Yes <input type="radio"/> No | High blood pressure <input type="radio"/> Yes <input type="radio"/> No |
| Damaged heart valves <input type="radio"/> Yes <input type="radio"/> No | Other congenital heart defects <input type="radio"/> Yes <input type="radio"/> 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



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 PRACTICES
You may refuse to Sign this Acknowledgement

Signature: _____

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