HEALTH HISTORY & REGISTRATION

PLEASE CHECK ONE:
I give my permission for you to call my home tel. no., cell no. and work no. as needed.

YES ________ NO ________

Name ______ Birthdate ______ Age ______ Today's Date ______

Home Address ______ City ______ State ______ Zip ______

Please Circle One: Single Married Separated Divorced Widowed Home Phone Number ______

Name of Spouse (Parent if Minor) ______ Person Responsible for Account ______

Cell Phone Number ______ E-mail ______ ☐ Yes ☐ No Address (If Different from Home Address) ______

Your Employer ______ Your Soc. Sec. # ______ Work Phone ______

Spouse's Employer ______ Spouse's Soc. Sec. # ______ Spouse's Birthdate ______ Spouse's Work Phone ______

Primary Dental Insurance Co. ______ Subscriber's Name ______

Address ______ Phone Number ______ Relationship ______ Group # ______

Secondary Dental Insurance Co. ______ Referred to us by (Important) ______

Reason for this visit ______

Who should be notified in case of an emergency? ______

Relationship ______ Phone Number ______

Name and Address of a Relative ______

or Friend Not Living with you... ______

Phone Number ( ) ______

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire...use reverse side if necessary.

• MEDICAL HISTORY •

Yes	Do you have any CURRENT HEALTH PROBLEMS?	NO
Yes	Are you under a PHYSICIAN'S CARE within the last 5 years?	NO
	For what?	
	Have you had any of the following?	
Yes	Rheumatic Fever, Heart murmur or heart valve problem?	NO
Yes	Any type of Heart Problem, Angina, Chest Pain or Surgery?	NO
Yes	High Blood Pressure, Low Blood Pressure, or Stroke?	NO
YES	Diabetes? Any Maternal, Paternal Diabetes?	NO
YES	Fainting Spells, Seizures, or Epilepsy?	NO
YES	ULCERS or Stomach problems?	NO
YES	Nervous Problems?	NO
YES	Asthma, or any Respiratory Problems?	NO
YES	Hepatitis, or any Liver Damage?	NO
YES	Abnormal bleeding, Anemia, Leukemia, or Blood Transfusion?	NO
YES	Surgery or Radiation for any Growths or Tumors?	
YES	Are you taking ANY MEDICATION now? Use additional sheet if necessary. Name them:	NO
YES	Are you Allergic to Penicillin or any other Antibiotics?	NO
YES	Are you Allergic to Codeine, Aspirin, or other pain medication?	NO
YES	Any Drug Allergies or Local Anesthetics?	NO
YES	Kidney or Bladder Problems? Swollen Ankles?	NO
YES	Arthritis?	NO
YES	Prosthetic Replacement - Hip, Knee, Heart Valve, Other?	NO
YES	Psychiatric care, Stress Therapy, Counseling?	NO
YES	Have you been exposed or been tested HIV Positive (AIDS)?	NO
YES	Measles? Mumps?	NO
YES	Taken hallucinogenic drugs, LSD, Crystal/Meth. etc.?	NO
YES	(Women) Are you Pregnant? Date Due?	
	Date of last physical examination	

FAMILY PHYSICIAN ______ PHONE NO. ______

Is there any other Medical or Dental Information that you feel I should know about?

______

PATIENT'S SIGNATURE ______ DATE ______

PARENT (IF CHILD) ______

DENTIST'S SIGNATURE ______ DATE ______

• DENTAL HISTORY •

	How LONG SINCE you have seen a Dentist:	
	Last COMPLETE Dental Exam, Date:	
	Last FULL MOUTH X-RAYS, Date:	
	(machine that rotates around your head, or 16 small films.)	
YES	Are you having PROBLEMS now?	NO
	WHAT?	
YES	Has your dental care been IRREGULAR in the last 5 years?	NO
YES	Is your present dental health POOR?	NO
YES	Do you think you will lose all your teeth soon?	NO
YES	Do you expect to wear DENTURES someday?	NO
YES	Have you had BAD dental experiences in the past?	NO
YES	Are you APPREHENSIVE about dental treatment?	NO
YES	Have you been given a local anesthetic?	NO
YES	Are you dissatified with any PAST dental treatment?	NO
YES	Have you had any PERIODONTAL (GUM) treatments?	NO
YES	Have GUM TREATMENTS ever been RECOMMENDED to you?	NO
YES	Are you troubled by BAD BREATH?	NO
YES	Does food usually WEDGE between certain teeth?	NO
	Where?	
YES	Do your gums BLEED, or feel TENDER or IRRITATED? (circle)	NO
YES	Are your teeth sensitive to HOT, COLD, SWEETS, PRESSURE? (circle)	NO
YES	Are you UNHAPPY with the APPEARANCE of your teeth?	NO
YES	Are you aware of GRINDING, or CLENCHING your teeth?	NO
YES	Are your jaws or teeth SORE when you awake from sleep?	NO
YES	Do you have HEADACHES, EARACHES, or NECK PAIN?	NO
YES	Have you LOST any teeth, other than wisdom teeth?	NO
YES	Have the lost teeth been REPLACED?	NO
YES	Has REPLACEMENT been RECOMMENDED to you?	NO
YES	Do you have LOOSE, TIPPED, or SHIFTING teeth? (circle)	NO
YES	Have you worn BRACES on your teeth? (ORTHODONTICS)	NO
YES	Have you had the NERVES of any teeth REMOVED? (Root Canals)	NO
YES	Have any teeth DARKENED from nerve removal? (Root Canals)	NO
YES	Have any teeth DISCOLORED from old fillings?	NO
YES	Does this discoloration BOTHER you?	NO
YES	Do you have problems with teeth/fillings BREAKING?	NO
YES	Do you REGULARLY use DENTAL FLOSS?	NO
YES	Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth?	NO
YES	Do you have Head/Jaw pain or an Injury?	NO
	Name of Previous Dentist:	
	City: State:	

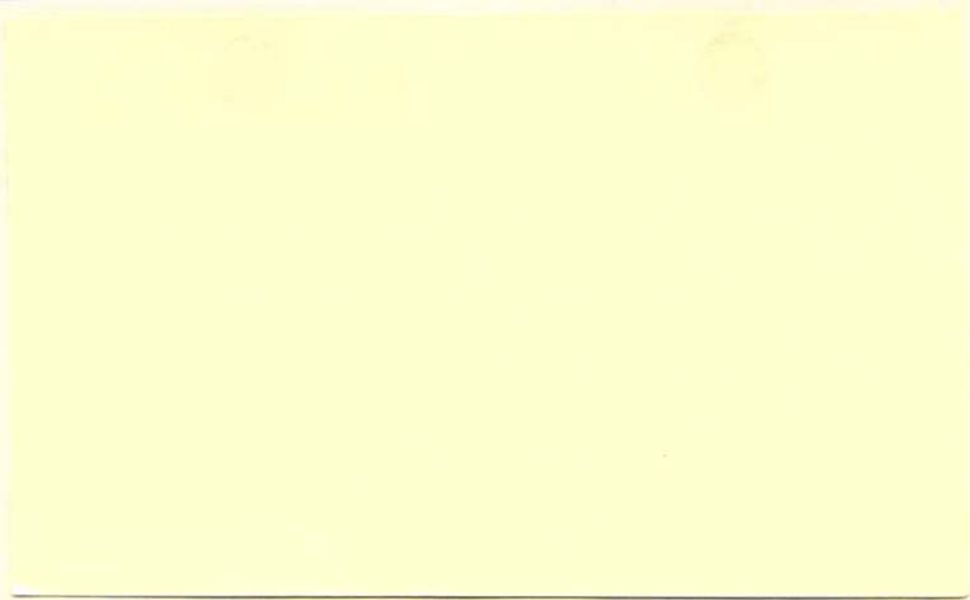
Are there any concerns or changes that you would like to make to your teeth? Describe

______

Please RANK the following in the order in which they would KEEP YOU FROM HAVING DENTAL TREATMENT...

FEAR of pain # ______ LACK of concern # ______

COST of treatment # ______ MISSING WORK TIME # ______



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
- Tooth-colored fillings
- Natural-looking crowns & bridges
- Porcelain veneers
- Pediatric dentistry
- Dental implant restorations
- Dentures & partials
- Gentle ultrasonic cleanings
- TMJ diagnosis & treatment
- Root canals
- Anti-snoring appliances & mouthguards
- Invisalign

CARING & CONVENIENCE FROM OUR FAMILY TO YOURS:

- Over four decades of excellence
- Father & son dentists
- Friendly, caring & capable staff
- Patient focused care & superb service
- State-of-the-art methods & equipment
- 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: ______________________________________

____

____

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)