THEODORE J. GRELLNER, DDS, PA

BOARD-CERTIFIED ORAL AND MAXILLOFACIAL SURGEON

Experienced Specialist. Advanced Methods. Individualized care.

Name_____

Address_____Apt #_____ [ ] Male [ ] Female

City_____ State_____Zip_____DOB_____/_____/_____

E-mail_____ Cell # (_____)_____ Home # (_____)_____

Employer_____ Work # (_____)_____

Spouse's Name_____ Use as a contact [ ] Yes [ ] No

Spouse's occupation _____ Work # (_____)_____

Is patient a full time student? [ ] No [ ] Yes: Name of school_____

How did you hear about us? (circle one please)

Dentist / Friend / Insurance / Our Website / Email / Google Ad / Google Video / Google Post / Facebook / Instagram / YouTube / LinkedIn

Responsible Party (if different than patient)

Name_____Relationship_____ Work # (_____)_____

Address_____ Home # (_____)_____ DOB _____/_____/_____

Dentist_____ Referred by_____

IN ORDER TO FILE WITH YOUR INSURANCE WE NEED ALL INFORMATION REQUESTED

DENTAL INSURANCE

Subscriber's Name_____ Relationship to patient_____

DOB_____/_____/_____ Subscriber's ID #_____ Group # _____

Name of Insurance _____ Subscriber's Employer_____

MEDICAL INSURANCE (required only if Dental insurance requires submission to Medical first)

Subscriber's Name_____ Relationship to patient_____

DOB_____/_____/_____ Subscriber's ID #_____ Group # _____

Name of Insurance _____ Subscriber's Employer_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Subscriber's Name_____ Relationship to patient_____

DOB_____/_____/_____ Subscriber's ID #_____ Group # _____

Name of Insurance _____ Subscriber's Employer_____

Patients, please tell us more about yourself_____

List hobbies_____

Favorite Book(s)_____

Favorite Movie(s)_____

Birthplace_____

Do you have any fears or concerns about your appointment today?

_____

MEDICAL HISTORY AND CONSENT

Please list any and all medications taken, including prescription medication, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage/Freq.	Prescriber	Reason
1.			
2.			
3.			
4.			
5.			
6.			

List any surgeries or hospitalization you have had:

Date (year)	Surgery	Surgeon	Reason
1.			
2.			
3.			
4.			
5.			
6.			

List and detail any medical conditions or history not listed above:

_____

_____

_____

Primary Physician's Name_____ Physician's Phone #_____

Are you under the care of physicians? If so, please list:

Physician Phone # Reason

_____

_____

_____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Dr. Theodore J. Grellner, DDS, P.A. to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make thorough diagnosis of the undersigned patient's dental condition and needs. To best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my/the patient's health. It is my responsibility to inform this office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 ½% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Dr. Theodore J. Grellner, D.D.S., P.A. and his staff to very insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits and to handle any necessary claim appeals.

Consent (adult):

_____

Name of Patient *Signature of Patient* Date

Consent for a minor:

_____

Name of Parent/Guardian *Signature of Parent/Guardian* Date

Notice of Privacy Practices

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____

Signature of Patient Date

HEALTH HISTORY

Patient's Name | Date of Birth | Height | Weight | Date

Answer all questions by circling Yes (Y) or No (N)

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:..... Y N

   _____

   _____
6. Do you exercise? What type? How often?_____

   _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma?..... Y N
   - N. Osteoporosis? ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - P. Radiation (X-ray) treatment for Cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - R. Sinus or Nasal problems? ..... Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? . Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N

All responses are kept confidential

- I. ..... Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa) ? ..... Y N
- J. Have you ever been advised <u>not</u> to take a medication? .....Y N
- K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____

  _____

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)? .....Y N
   - B. Penicillin or other antibiotics? .....Y N
   - C. Sedatives, Barbiturates? .....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers? .....Y N
   - F. Latex or Rubber products? .....Y N
   - G. Metal of any kind? .....Y N
   - H. Chemicals or jewelry (rash or sensitivity)? .....Y N
   - I. Food products? .....Y N
   - J. Other allergies or reactions? Please list.....Y N

   _____

   _____
10. Do you smoke or chew Tobacco? .....Y N
    How much per day? _____
11. Are you exposed to marijuana……Y N
12. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
13. Have you had any serious problems associated with any previous dental treatment? ..... Y N
14. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
15. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
16. Do you wish to talk to the doctor privately about anything? ..... Y N
17. Have you ever had a bone density scan? ..... Y N
18. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist Dr. Grellner in providing the best care possible. I have had the opportunity to discuss my Health History with Dr. Grellner.

Date | Signature of Person Completing Health History | Doctor's Initials

UPDATE TO HEALTH HISTORY: I have reviewed and made necessary changes to my Health History

Date | Signature of Person Completing Health History | Doctor's Initials

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on March 31, 2005 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Carmen Olson-George. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page and the staff time charged will be $15.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US

Practice Name: THEODORE J. GRELLNER D.D.S, P.A.

Privacy Officer: Ginny Masson

Telephone: 813-972-3478 Fax: 813-972-1782

E-Mail: info@grellnerdds.com

Address: 15310 AMBERLY DRIVE SUITE 195 TAMPA, FL 33647