GRANTS PASS DENTAL

Jed Ledesma D.D.S.

Personal Information

Name: _____ DOB: _____ / _____ / _____
First (Preferred Name) Middle Initial Last

Social Security #: _____ Marital Status: _____ ❑ Male ❑ Female

Physical Address: _____
Street City State Zip

Mailing Address: ❑ check if same _____
Street City State Zip

Primary Phone #: _____ Secondary Phone #: _____ Email: _____

Employer: _____ Occupation: _____ Phone #: _____

Spouse or Guardian Name: _____ Employer: _____ Phone #: _____

Person to contact in case of Emergency: _____ Relationship: _____ Phone #: _____

How did you hear about us: ❑ Website ❑ Building signs ❑ Referred by: _____ ❑ Other: _____

Responsible Party

Name of Person Responsible for this account: _____ DOB: _____ / _____ / _____

Relationship to Patient: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Social Security #: _____ Driver's License #: _____ Email: _____

Payment: ❑ Cash ❑ Personal Check ❑ Visa ❑ MasterCard ❑ Discover ❑ Care Credit ❑ Discuss w/ Office Manager

Primary Insurance

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____

Insurance Group: _____

Insurance Policy/I.D. #: _____

Insured's Name: _____

Relationship to Patient: _____

DOB: _____ / _____ / _____ SS#: _____

Employer: _____ Phone: _____

Secondary Insurance

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____

Insurance Group: _____

Insurance Policy/I.D. #: _____

Insured's Name: _____

Relationship to Patient: _____

DOB: _____ / _____ / _____ SS#: _____

Employer: _____ Phone: _____

Patient/Guardian Signature: _____ Date: _____ / _____ / _____

GRANTS PASS DENTAL

Patient: _____ DOB: _____ / _____ / _____

Dental History

Why are you here today? _____

When was your last dental exam? ❑ within the past year ❑ 1-2 years ago ❑ 3-5 years ago ❑ 5+ years ago

Is there anything about your mouth/smile you would like to change? _____

Dental Conditions and Concerns (check all that apply)

❑ Broken/Loose Teeth ❑ Chew on Ice/Finger nails ❑ Bleeding gums ❑ Infection/Abscess ❑ Sleep Apnea/Snoring
❑ Broken Filling/Crown ❑ Dry Mouth/ Mouth Breathing ❑ Frequent Headaches ❑ Jaw Pain/Clicking ❑ Spaces between teeth
❑ Cavities ❑ Old Fillings/crowns ❑ Sores or Bumps
❑ Clenching/Grinding ❑ Gagging ❑ High anxiety ❑ Sensitivity Teeth ❑ Other: _____

Desired Dental Treatment (check all that apply)

❑ Braces ❑ Cleanings ❑ Esthetics ❑ Implants ❑ Teeth Whitening
❑ Bridges ❑ Crowns ❑ Extractions ❑ Night Guard ❑ Veneers
❑ Cavity Prevention ❑ Dentures/Partials ❑ Fillings (white/silver) ❑ Nitrous Oxide ❑ Other: _____

Medical History

Name of your physician/specialist: _____ Office #: _____

Are you currently seeing a physician/specialist for a specific medical condition? ❑ Yes, and why: _____ ❑ No

Medications (check all that apply)

Are you currently taking any medications? ❑ Yes ❑ No

Are you taking any **BLOOD THINNERS**? ❑ Coumadin ❑ Eliquis ❑ Warfarin ❑ Xarelto ❑ Other: _____

Are you taking any **BISPHOSPHONATE**? ❑ Actonel ❑ Boniva ❑ Fosamax ❑ Zometa ❑ Other: _____

Please list medications: _____

_____

Allergies (check all that apply)

❑ Anesthetic ❑ Codeine ❑ Latex ❑ Sulfa ❑ Other: _____
❑ Aspirin ❑ The Dentist ❑ Penicillin ❑ Tylenol ❑ I have no known allergies

Health Conditions (check Yes or No)

Y	N		Y	N		Y	N		Y	N	
❑	❑	Arthritis	❑	❑	Dialysis	❑	❑	Liver Disease	❑	❑	Thyroid Conditions
❑	❑	Alzheimer's/Dementia	❑	❑	Fainting/Vertigo	❑	❑	Kidney Disease	❑	❑	Tobacco Use
❑	❑	Angina/Chest Pains	❑	❑	Glaucoma	❑	❑	Pacemaker	❑	❑	Tuberculosis (TB)
❑	❑	Artificial Joint(s)	❑	❑	Headaches/Migraines	❑	❑	Psychiatric Care/PTSD	❑	❑	Tumors
❑	❑	Autism	❑	❑	Heart Attack/Stroke	❑	❑	Rheumatic Fever	❑	❑	Other: _____
❑	❑	Back Pain	❑	❑	Heart Disease	❑	❑	Seizures/Epilepsy			_____
❑	❑	Blood Condition	❑	❑	Heart Murmur						
❑	❑	Blood Pressure High/Low	❑	❑	Hepatitis A, B, or C						
❑	❑	Cancer	❑	❑	HIV/AIDS						
❑	❑	Chemo/Radiation	❑	❑	Illicit Drug Use						
❑	❑	Diabetes	❑	❑	Infective Endocarditis						

Y	N	**WOMEN ONLY**
❑	❑	Are you pregnant?
❑	❑	Are you on birth control?
❑	❑	Are you nursing?

Additional Comments: _____

Patient/Guardian Signature: _____ Date: _____ / _____ / _____

GRANTS PASS DENTAL

Patient: _____ DOB: _____ / _____ / _____

Authorization, Release, & Consents

Appointments and Cancellations

It is our policy to give patients reminder cards and a courtesy phone reminder of upcoming appointments. Frequently, we need to leave a voice mail or message with a person other than the patient. By affixing your signature below, you allow staff of GP Dental to leave messages or confirmation of your appointment on the above referenced communication system and/or with persons other than yourself. Remember a confirmed appointment is time and resources reserved specifically for you. We require a minimum of 24 hours to cancel an appointment. If a cancellation occurs within this 24-hour period, or an appointment is failed without notice, a $50 fee will be charged for a hygiene appointment and a $100 fee will be charged for a restorative appointment.

Financial Policy

Unless other arrangements have been made in advance, FULL PAYMENT IS DUE AT TIME OF SERVICE. For your convenience we accept cash, check, Visa, Mastercard, Discover, and Care Credit. Returned checks are subject to a $25 penalty per check. In the event of default on my part, I agree to pay legal interest on the indebtedness, together with such collection costs, reasonable attorney's fees, and other responsible expenses incurred at GP Dental as may be required for the collection of debt. Your insurance policy is a contract between you and your insurance company, the doctor is not involved. As a courtesy, DP Dental will bill indemnity insurance plans directly. I authorize payment directly to GP Dental of any benefits otherwise payable to me from my insurance company or dental benefit plan. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for all services rendered on my behalf or on the behalf of my dependents.

Privacy Practice

We are required by applicable federal law to maintain the privacy of your health information. We are also required to give you a 'Notice of Privacy Practices', containing your legal duties and rights concerning your health information. You may request a copy of our Privacy Practice from the office front desk at any time. I certify all information provided is done at best of my knowledge. I understand that providing incorrect information is dangerous to my health. When it is appropriate and necessary, GP Dental provides personal health information to essential indirect parties such as dental labs, dental and medical specialists, insurance companies, etc. All health information will be in accordance to HIPPA guidelines. You may refuse to consent to the use or disclosure of your personal health information, which must be done in writing. Under this law we have the right to refuse to treat you should you choose to refuse to disclose personal health information.

Treatment Consent

I consent to allow authorized employees of GP Dental to take radiographs, impressions for study models, photographs, perform or order tests, and any other diagnostic aids deemed necessary, along with performing any form of treatment, medication, and/or therapy that may be indicated in connection with treating the diagnosed conditions. I understand the use of an anesthetic agent embodies a certain risk. I consent and authorize GP Dental to release any and all information about my dental condition and treatments to my insurance company as may be required to obtain benefits from them. I will not hold GP Dental responsible for any omissions or incomplete medical/dental forms.

I CERTIFY THAT I HAVE READ & UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE

Patient/Guardian Signature: _____ Date: _____ / _____ / _____