GREEN DENTAL

CHANGING FACES CHANGING LIVES

We Welcome New Patients

ABOUT YOU

Today's Date: _____

Name: _____

Birthdate: _____/_____/_____

Age:_____ SS#:_____

Home Address: _____

_____

Email: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: _____Cell Phone:_____

Employer: _____Work Phone:_____

How long there? _____ Occupation: _____

Whom may we Thank for referring you?

Other family members seen by us: _____

_____ _____ _____

SPOUSE /PARENT INFORMATION

Name: _____

Employer: _____Work Phone:_____

Birthdate: ____/_____/_____

Financial Responsibility for this account

Name: _____

Work Phone: _____Cell Phone:_____

Billing Address: _____

Relationship: _____SS#_____

Employer: _____Work Phone:_____

Signature: _____

Signature must match name and ID on file

DENTAL INSURANCE

Primary Dental Insurance

Ins Co. Name: _____

Ins Co. Address: _____

Ins Co. Phone #: _____

Group(plan, local or policy) **#: _____**

Member #: _____

Insured Name: _____Relation: _____

Insured Birthdate: ___/___/___Insured SS#_____

Insured Employer: _____

Secondary Dental Insurance

Ins Co. Name: _____

Ins Co. Address: _____

Ins Co. Phone #: _____

Group(plan, local or Policy)#: _____

Member #: _____

Insured Name: _____Relation: _____

Insured Birthdate: ___/___/___ SS# _____

Insured Employer: _____

MEDICAL & DENTAL HISTORY

Do you have a personal physician? ☐☐

Physician's Name:_____

Phone #:_____ Last Visit Date: ___/___/___

Date of last physical exam: ___/___/___

Required: List Emergency Contact

Their Name:_____

Relation:_____

Work Phone: _____Cell Phone:_____

GREEN DENTAL
CHANGING FACES CHANGING LIVES

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Have you ever had any of the following diseases or medical problems?

Check Y column for Yes and N **column** for No.

Y	N		Y	N		Y	N	
☐	☐	Heart attack	☐	☐	Artificial Bones/Joints	☐	☐	Ulcers
☐	☐	Stroke	☐	☐	Artificial Heart Valves	☐	☐	Hemophilia/Abnormal Bleeding
☐	☐	Cancer	☐	☐	Difficulty Breathing	☐	☐	Colitis
☐	☐	Chemotherapy	☐	☐	Sinus Problems	☐	☐	Congenital heart Defect
☐	☐	Radiation Treatment	☐	☐	High Blood Pressure	☐	☐	Anemia
☐	☐	Heart Murmur	☐	☐	Low Blood Pressure	☐	☐	Arthritis
☐	☐	Heart Surgery	☐	☐	Do you snore	☐	☐	Asthma
☐	☐	Pacemaker	☐	☐	Depression/Mental Health	☐	☐	Emphysema
☐	☐	Mitral Valve Prolapse	☐	☐	Epilepsy/Seizures/Fainting	☐	☐	Hepatitis
☐	☐	Rheumatic Fever	☐	☐	Diabetes|Last A1C ____	☐	☐	Blood Transfusion
☐	☐	HIV +/AIDS	☐	☐	Tuberculosis (TB	☐	☐	Severe/Frequent Headaches
☐	☐	Shingles	☐	☐	Drug Abuse	☐	☐	Have you had a sleep study
☐	☐	Kidney Problems	☐	☐	Alcohol Abuse	☐	☐	Do you use a C Pap machine

For Women:

Y	N	
☐	☐	Birth Control?
☐	☐	Pregnant?
☐	☐	Nursing?
☐	☐	Planning Pregnancy?

For Sedation purposes:

Approx Height:

Approx Weight:

Any medical conditions we should be aware of?

Are you allergic to the following drugs?

Y	N		Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Tetracycline	☐	☐	Sulfa
☐	☐	Aspirin	☐	☐	Dental Anesthetic	☐	☐	Latex
☐	☐	Erythromycin	☐	☐	Codeine	☐	☐	Other

Please list any other drugs that you are allergic to:

Have you been hospitalized in the last 5 years? Why?

Do you have artificial joint replacements? ☐☐ **If Yes, please explain:**

Do you need to take antibiotics prior to treatment? ☐☐

Are you currently under the care of a physician? ☐☐

Have you traveled outside of the U.S. in the last 6 months? ☐☐

Do you smoke/vape or chew tobbaco? ☐☐

GREEN DENTAL
CHANGING FACES CHANGING LIVES

DENTAL HISTORY

Patient Name: _____ Date of Birth: _____

Your current Dental Health is:

Excellent ☐ **Good** ☐ **Fair** ☐ **Poor** ☐

How important is it that you retain your natural teeth?

Not important ☐ **Somewhat Important** ☐ **Extremely Important** ☐

How important is dental treatment cost to you?

Not important ☐ **Somewhat Important** ☐ **Extremely Important** ☐

Do you experience dental related anxiety? ☐ ☐

Do you or have you experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ ☐

Do you like your smile? ☐ ☐

Do your gums ever bleed? ☐ ☐

How many times a week do you floss? ☐

How many times a day do you brush? ☐

Have you ever had serious or difficult problems associated with any previous dental work?

What concerns or goals would you like us to address at today's visit?

What influenced your decision to transition your care to our office?

Payment for our services must be made in full at the time of scheduling your appointment, due to the nature of sedation, unless prior arrangements have been approved.

Our office is dedicated to adhering to, and even surpassing, the infection control standards set forth by **OSHA**, the **CDC**, and the **ADA.**

I understand that the administration of local anesthetic may cause an unfavorable reaction or side effect, which my include, but are not limited to,, bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely permanent numbness.

I acknowledge that the information I have provided today is accurate to the best of my knowledge. I also understand that this information will be treated with the utmost confidentiality, and it is my duty to notify this office of any changes regarding my medical condition. **I grant permission** for the dental staff to carry out any necessary dental services with my informed consent during the diagnosis and treatment process. Additionally, **I authorize** this office to arrange credit on my behalf if needed. Should my account go into delinquency, I will be responsible for all costs incurred during collection efforts, including attorney's fees, court costs, and a collection agency fee of 30%.

Signature: _____ Date: _____

by signng, you are agreeing you are the financial responsible party. Please as the front desk for assistance.

GREEN DENTAL
CHANGING FACES CHANGING LIVES

MEDICAL INFORMATION RELEASE

Patient Name: _____ Date of Birth: _____

I, authorize Green Dental to disclose my medical and dental information to the following individuals: (we recommend spouse, anyone bringing you to a sedated appointment, anyone you would have call on your behalf)

Authorized Individuals:

1. Name: _____Relationship: _____Phone Number_____
2. Name: _____Relationship: _____Phone Number_____
3. Name: _____Relationship: _____Phone Number_____

I understand that these individuals may receive verbal, written, or electronic communication regarding my dental treatment, appointments, insurance, and billing inquiries.

Authorized Methods of Contact to myself as the patient: (Please check all that apply)

☐Home Phone ☐Cell Phone ☐Work Phone ☐Email ☐Text Message

Messages:

☐Leave a detailed message ☐Leave only a call-back number ☐Do not leave messages

I understand that this authorization will remain in effect unless I provide written notice to revoke or modify it. I also acknowledge that Green Dental cannot be held responsible for information released prior to the receipt of my written revocation.

Patient Signature: _____ Date: _____

GREEN DENTAL
CHANGING FACES CHANGING LIVES

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

Patient Name: _____
Date of Birth: _____

Authorization for Submission of Claims
I authorize Green Dental to submit insurance claims on my behalf and release necessary information, including dental history, diagnosis, and treatment, to process those claims.
I understand:

- A submitted claim does not guarantee payment.
- Any treatment plan is an estimate, not a guarantee of insurance coverage.
- I am responsible for understanding my insurance benefits.
- I am responsible for the full balance if insurance denies or delays payment.

Assignment of Benefits
I assign all dental benefits to Green Dental and authorize direct payment from my insurance carrier.
I agree to:

- Forward any insurance payments sent directly to me within 30 days.
- Obtain referrals or pre-authorizations if required by my policy. I understand this is my responsibility, not the provider's.

Financial Responsibility
I am responsible for any remaining balance after insurance processing. Payment is due at the time of service unless other arrangements have been made. Any balance must be paid within 30 days of insurance payment.

Electronic Claims & Communication
I consent to the electronic submission of claims and communication between Green Dental and my insurance provider.

A**cknowledgment & Agreement**
I have read, understand, and agree to the terms above. I accept financial responsibility for services provided and understand unpaid balances may incur additional fees or collection action.

Signature: _____

Date: _____

GREEN DENTAL
CHANGING FACES CHANGING LIVES

DR. BROOKS A. GREEN DR. GORDON K. GREEN DR. NICHOLE L. BARNETT

CANCELLATION POLICY

At Green Dental, we reserve dedicated time in our schedule for each patient to receive the highest level of care. When an appointment is missed or canceled without sufficient notice, it prevents other patients from receiving timely treatment.

Appointment Cancellations

We kindly ask that all appointment cancellations or changes be made with at least 48 hours' notice. This allows us to offer that time to another patient in need.

No-Show Policy

If a patient misses an appointment without notifying us, it will be considered a "no-show."

- After the first no-show, a friendly reminder of this policy will be shared.
- Any future missed appointments without 48-hour notice may result in a $50 no-show fee added to the account.

Running Late?

We understand that life happens. If you're running behind, please call us as soon as possible. We'll do our best to accommodate you or find an alternative time.
We value your time, and we hope to offer that same courtesy to every patient. These guidelines help us:

- Minimize wait times
- Ensure efficient scheduling
- Keep treatment plans on track for all patients

Acknowledgment

As a patient of Green Dental, I have read, understand, and acknowledge this cancellation and no-show policy.

Name: _____ Date: _____