RICK L. GRANT, DMD, INC.

FAMILY DENTISTRY, ORTHODONTIC, IMPLANTS

New Patient Registration

Patient Information *(Individual being treated)*

Please Provide Copy of Driver's License

First Name: _____ Last Name: _____

Mailing Address: _____ City: _____State: _____ Zip: _____

Birth Date: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Gender: ☐ Male ☐ Female (E-mail): _____

Social Security Number:_____

Person to Contact in Case of Emergency: _____ Relation: _____ Phone: _____

Financially Responsible Party *(Person responsible for balances on account)*

First Name: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Gender: ☐ Male ☐ Female (E-mail):

_____

☐ *Responsible Party is also a Policy Holder for Patient* ☐ *Primary Insurance Policy Holder* ☐ *Secondary Insurance Policy Holder*

Who may we thank for referring you?_____

Other Referrals ☐ Internet ☐ Doctors Referral ☐ Walk by ☐ Drive By

I am interested in (Please check all that apply)

- □ General Dentistry
- □ Teeth Whitening
- □ Clear Aligner Therapy or Straighter Teeth
- □ TMJ or Teeth Grinding
- □ Snoring/Sleep Apnea
- □ Endodontics
- □ Implants (Single or Dentures)
- □ Oral Surgery (Extractions, Wisdom Teeth Removal, Sinus Lift, Bone Preservation)

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Primary Benefit Information

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of **individual Policy Holder**: _____ Name of **Benefit Company**: _____

Policy Holder Employer: _____ **Benefit Company** Address: _____

Employer Address: _____ City, State, Zip: _____

City, State, Zip:_____ Member ID: _____

Policy Holder Birth Date: _____ Group Number: _____

Policy Holder SSN: _____**Benefit Company** Phone # _____

Secondary Benefit Information

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of **individual Policy Holder**: _____ Name of **Benefit Company**: _____

Policy Holder Employer: _____ **Benefit Company** Address: _____

Employer Address: _____City, State, Zip: _____

City, State, Zip:_____ Member ID: _____

Policy Holder Birth Date: _____ Group Number: _____

Policy Holder SSN: _____**Benefit Company** Phone # _____

Ask About Our Membership

The Grant Plan Membership is designed to provide affordability and greater access to quality dental care. You will receive immediate, hassle-free, and convenient eligibility. Dental services will be provided by the Rick Grant Family Dentistry team.

This is a membership plan to provide affordable dental care, not dental insurance, or benefit plan. The plan may be enhanced as our services progress in the advancement of quality care. Patient portion is due at the time of service.

We make it simple for your investment to provide continuous care through our automatic renewal process.

Benefits of our membership:

- □ No deductible
- □ No annual maximum
- □ No pre-authorization
- □ No wondering what your benefits will pay toward your treatment
- □ No waiting period

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Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIIPPA), there are certain rights to privacy regarding my protected health information. I understand that this information will be used to:

*Contract, plan, and direct any treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third party payers

*Conduct normal healthcare operations such as quality assessments.

I acknowledge that I have received your Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I understand that this office has the right to change the Notice of Privacy Practices from time to time, and that I may contract the practice at any time at the address above, to obtain a current copy of the Notices of Privacy Practices

I understand I may request, in writing, that you restrict how my private information is used and disclosed to carry out treatment, payment or healthcare operations. I also understand you are required to agree to my requested restrictions and if you do agree, then you are bound to such restrictions.

Patient Printed Name: _____

Parent/Guardian Printed name: _____

Signature of Patient/Guardian: _____ Date: _____

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Mission

Our mission is to provide quality dental care, utilizing a minimally invasive approach that is designed to improve the health and lifestyle of every patient.

Our Core Values

Excellence: We pursue excellence in everything we do.

Positivity: We maintain a positive state of mind, regardless of circumstance.

Efficiency: We use simple and efficient systems to maintain punctuality.

Authenticity: We are authentic in our interactions, and genuinely believe in our team's values.

Growth: We thirst for personal and professional development.

Selfless: We selflessly serve our patients and each other.

Your Rights

Restrictions: You have the right to request restrictions or disclosure of usage. We are not required to accept these restrictions, but we will make a note of the request and honor that request if applicable.

Access: You have the right to access your personal dental information. A request for access must be made in writing. You may speak to our office manager to schedule an appointment to view your information. You may also request a copy of your personal dental information.

Amendment: You have the right to request that we amend your personal health information. Your request must be in writing and explain what should be amended and the rationale for such a request. We have the right to deny this request if we feel that it would render your information inaccurate. We will inform you of the decision to amend your information.

Disclosures: You have the right to request a list of the times and entities to whom we have disclosed your personal dental information. These disclosures are only for instances other than treatment, payment, or operations. This disclosure will be given free on an annual basis if requested. We reserve the right to charge for this if requested more than once in a 12-month period.

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Record Maintenance

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies, but you will be informed of any changes in advance. We will only release information about you and your treatment under specific circumstances. These include, but are not limited to the following:

Treatment: We may use your information during treatment. This includes releasing information to other dentists and our staff.

Payment: We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes benefit carriers, claims clearing houses, and collection agencies.

Operations: We may use your personal information during operations of our office. This may include quality assurance/quality improvement reviews, credentialing, training, and certification and accreditation activities.

Miscellaneous Uses: At certain times we may be required to use your information for other purposes than as described above. Examples of these include: appointment reminders (cards, voice messages, and letters), immediate family and friends (only to the extent for use in healthcare operations or payment), schools (letter excusing absence due to dental treatment), education (use of information in presentations or lectures regarding treatment or procedure), and in some cases to law enforcement and court ordered releases (coroner, worker's compensation, automobile policies, and life insurance policies).