GRIECO
Biological, Cosmetic & Holistic Dentistry
Healthy Smiles...Naturally

# Dental Registration

Please answer the questions on this form so that we may better assist you with your dental needs.

## Personal

Patient Name: ______________________________ Today's Date: ______________
Last Name First Name Middle Initial

Soc. Sec. #: ______________ Birthdate: ______________ Age: ________ Sex: M F

Address: ______________________________ City: ______________

State: __________ Zip: __________ Home Phone: ______________ Cell Phone: ______________

I prefer to be contacted at: Home Work Cell Marital Status: Minor Single Married Other __________

Email: ______________________________

Employer: ______________________________ Business Phone: ______________

Business Address: ______________________________ Occupation: ______________

Incase of emergency, who should we contact? ______________________________ Phone: ______________

Person Responsible for Account: ______________________________ Relationship to Patient: ______________

**Note To Patients With Dental Insurance:** (Please provide your information to receptionist)

Dr. Grieco does not participate with any insurance companies and is considered to be an out of network dentist by your dental plan. **In most cases, you will still be able to receive benefits from your dental insurance.** If you are concerned about what will and will not be covered, it is your responsibility to contact the insurance company. We require that you either pay your bill, in full, at time of service or make financial arrangements with the financial advisor beforehand. Our office will fill out all the necessary paperwork for your insurance company. It is your responsibility to submit the paperwork needed to receive your benefits. The insurance company will then send the reimbursement check directly to you. Please present your dental insurance card to the person at the front desk so that we may properly complete your paperwork.
**Attention patients under medical assistance or with medicare, medicaid, security blue or a dental HMO.** Dr. Grieco is not a provider with any of these programs. Because of this you will not receive any benefits from your dental plan should you have treatment done at our office. If you wish to become a patient we will be very happy to have you, but please keep in mind that you will be responsible to pay your bills in full at time of service.

## Medical History

Although dental personnel primarily treat the area in and around your mouth, it is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will be receiving.

| | Yes | No |
|---|---|---|
| 1. Are you currently under medical treatment? ……….. | ☐ | ☐ |
| 2. Have you ever had any serious illness or operations? | ☐ | ☐ |
| Please explain: ______________ | | |
| 3. Are you currently taking any medication? ………….. | ☐ | ☐ |
| **Please list**: ______________ | | |
| 4. Do you use any tobacco products? ………………….. | ☐ | ☐ |
| Please list: ______________ | | |
| 6. Do you wear contact lenses? ………………………... | ☐ | ☐ |
| 7. Are you **allergic** to or have you had reactions to: | | |
| Local Anesthetics like Novacaine or Carbocaine…. | ☐ | ☐ |
| Penicillin or other Antibiotics (list) __________ | ☐ | ☐ |
| Sulfa Drugs ……………………………..………… | ☐ | ☐ |
| Barbiturates, Sedatives or Sleeping Pills …………… | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Congenital Heart Problem……………...………….. | ☐ | ☐ |
| Hepatitis, Jaundice, or Liver Disease ……………….. | ☐ | ☐ |
| Diabetes …………………………………………….. | ☐ | ☐ |
| Asthma ……………………………………………… | ☐ | ☐ |
| Anemia ……………………………………………… | ☐ | ☐ |
| Cold Sores / Fever Blister …………………………... | ☐ | ☐ |
| Epilepsy or Seizures ………………………………… | ☐ | ☐ |
| Sexually Transmitted Disease ……………………… | ☐ | ☐ |
| AIDS or HIV Infection ……………………………... | ☐ | ☐ |
| Chemotherapy (Cancer, Leukemia) ………………… | ☐ | ☐ |
| Mental Health Care …………………………………. | ☐ | ☐ |
| Chemical Dependency……………………………. | ☐ | ☐ |
| Eating Disorders ………………………………… | ☐ | ☐ |

**(There is a back)**

**Allergies (cont.)**

Aspirin …………………………………………………. ☐ ☐

Iodine ……………………………………………... ☐ ☐

Any Metals (e.g. Nickel, Mercury)(list) ______________ ☐ ☐

Latex / Rubber ………………………………………. ☐ ☐

Other (Please list) ____________________________

8. Do you or have you ever had any of the following:

Rheumatic Heart Disease or Rheumatic Fever……… ☐ ☐

Scarlet Fever ……………………………………… ☐ ☐

Heart Defect or Heart Murmur …………………….. ☐ ☐

Organ Transplant or Joint Replacement / Implant ….. ☐ ☐

Mitral Valve Prolapse ………………………………. ☐ ☐

9. Is there any other health conditions, which are not listed above, that we should be aware of? ……….. ☐ ☐

Please list: _________________________________

10. Have you ever been instructed to premedicate prior to dental appointments? …………………………….. ☐ ☐

If Yes, what antibiotic were you prescribed? ________

11. (WOMEN ONLY) Are you:

Pregnant or Think you may be pregnant ..…………... ☐ ☐

Nursing ……………………………………………… ☐ ☐

Taking birth control ………………………………… ☐ ☐

## Covid-19 Screening

| | Yes | No |
|---|---|---|
| 1. Have you traveled anywhere recently that are locations of disease outbreak? | ☐ | ☐ |
| 2. Have you been in contact with anyone who was sick recently? | ☐ | ☐ |
| 3. Have you attended any large group functions recently? | ☐ | ☐ |

4. Have you had any of the following symptoms within the last two weeks:
   - ☐ Fever
   - ☐ Fatigue
   - ☐ Dry cough
   - ☐ Altered taste
   - ☐ Altered smell
   - ☐ Trouble breathing
   - ☐ Productive cough (mucous in cough)
   - ☐ Muscle pain
5. Have you previously had the SAR-COV-2 virus (novel coronavirus)? If so, did you test positive and what test were you administered? ____________ ☐ ☐
6. Are you over the age of 65 and/or have preexisting health conditions related to the following…
   - ☐ Diabetes
   - ☐ Chronic Lung Disease or Asthma
   - ☐ Serious Heart Condition
   - ☐ Are you Immunocompromised?
   - ☐ Chronic Kidney Disease
   - ☐ Chronic Liver Disease

## Authorization and Release - *This section must be read and signed before treatment can be performed.*

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree to allow Dr. Derek P. Grieco, D.M.D. and his staff to treat my or my dependent's dental needs.

Signature of Patient or Parent of Minor: X_____________________________________________ Date: ____________________________

## NOTICE OF PRIVACY

HIPAA is the Health Insurance Portability and Accountability Act (HIPAA). It was put into place to protect patient privacy and also ensures privacy of all accumulated health information that belongs to the patient. It was signed into law in 1996 under the United States Department of Health and Human Services.

### Our Office Privacy Practices

All information that is obtained from you by Dr. Grieco is protected and kept confidential under then Health Insurance Portability and Accountability Act (HIPAA). Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

### Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information can be disclosed without your written authorization in certain limited circumstances such as: medical emergencies, in situations required by law, individuals involved in your care, when requested by public health agency, and when requested by a law enforcement agency.
- For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.
- Dr. Grieco may use your information for research or teaching purposes, but your name or face photo is never used.

### Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.
- You have the right to request an alternate means or location to receive communications regarding your health information.
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.

**KEEP IN MIND THAT IF YOU WANT YOUR MEDICAL RECORDS FROM OUR OFFICE SENT TO ANOTHER, YOU WILL HAVE TO SIGN A RELEASE FORM.**

______________________________ ________________________________ ______________

Print Name Signature Date