Mark Groskin DDS & Associates
1109 English Rd.
Rochester, NY 14616
585-225-7070
Fax# 585-225-1448
drggg.com

TODAY'S DATE_____

PATIENT NAME_____ SEX: __M__F BIRTHDATE_____
ADDRESS_____CITY_____STATE___ZIP_____
SS#_____PHONE#_____CELL#_____WORK#_____ EXT_____
EMAIL ADDRESS:_____

SINGLE_MARRIED_WIDOWED_SEPRARATED_DIVORCED_

OCCUPATION_____EMPLOYER_____
EMPLOYER ADDRESS_____ EMPLOYER PHONE # _____

SPOUSE'S NAME_____BIRTHDATE_____SOCIAL SECURITY#_____
OCCUPATION_____ EMPLOYER_____
SPOUSES EMPLOYER PHONE #_____ SPOUSE'S CELL#_____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household)
NAME_____ RELATIONSHIP_____
HOME PHONE#_____WORK PHONE#_____CELLPHONE#_____
HOW WERE YOU REFERRED TO OUR OFFICE? (phonebook, friend, insurance company, Newspaper ad etc.)_____
WHO IS RESPONSIBLE FOR THIS ACCOUNT?_____
RELATIONSHIP TO PATIENT_____
PRIMARY DENTAL INSURANCE:
DENTAL INSURANCE CO._____
SUBSCRIBER ID #_____KODAK 6 DIGIT ID #_____GROUP #_____
SUBSCRIBER'S NAME_____BIRTHDATE_____ SS#_____
SUBSCRIBER'S EMPLOYER_____
IS PATIENT COVERED BY ADDITIONAL INSURANCE __Y __N
RELATIONSHIP TO PATIENT_____ _____
SECONDARY DENTAL INSURANCE:
DENTAL INSURANCE CO._____
SUBSCRIBER ID #_____KODAK 6 DIGIT ID #_____GROUP #_____
SUBSCRIBER'S NAME_____ BIRTHDATE_____SS#_____
SUBSCRIBER'S EMPLOYER_____

ASSIGNMENT AND RELEASE
I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH_____ AND ASSIGN DIRECTLY TO DR. GROSKIN ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHEATHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DR. GROSKIN TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.
RESPONSIBLE PARTY SIGNATURE _____
RELATIONSHIP_____DATE:_____

HEALTH HISTORY

English

Patient Name:_____ Patient Identification Number:_____

Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER (Leave Blank if you do not understand question)

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____ Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, medications, latex?	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	50.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	No	Alcohol?

Please list:_____

_____

VI. WOMEN ONLY:

65.	Yes	No	Are you or could you be pregnant or nursing?	66.	Yes	No	Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date:_____

RECALL REVIEW

1. Patient's signature_____ Date:_____
2. Patient's signature_____ Date:_____
3. Patient's signature_____ Date:_____

The Health History is created and maintained by the University of the Pacific School of Dentistry, San Francisco, California.
Support for the translation and dissemination of the Health Histories comes from MetLife Dental Care.

PHYSICIAN'S NAME_____PHONE_____
LAST PHYSICAL EXAM_____
STEROID (CORTISONE) THERAPHY DURING THE LAST YEAR?____ IF YES, FOR HOW LONG?_____
MEDICATION/DOSAGES_____

_____

_____

ALLERGIES:
___LATEX __ASPIRIN __PENICILLIN ___SULFA __IODINE
___CODEINE __BARBITURATES __LOCAL ANESTHETIC

PLEASE TELL US A FEW INTERESTING FACTS ABOUT YOURSELF
(HOBBIES, ACTIVITIES etc)

1.
2.
3.
4.
5.

ARE YOU INTERESTED IN WHITENING?_____

DENTAL HISTORY:
REASON FOR TODAY'S VISIT_____
FORMER DENTIST_____
FORMER DENTIST PHONE#_____
DATE OF LAST DENTAL VISIT_____
DATE OF LAST DENTAL XRAYS_____
HAVE YOU HAD ANY BAD DENTAL EXPERIENCES, IS SO WHAT?_____
HOW OFTEN DO YOU FLOSS?_____ HOW OFTEN DO YOU BRUSH?_____

INDICATE IF YOU HAVE/HAD ANY OF THE FOLLOWING BY CHECKING THE APPROPRIATE LINE:

BAD BREATH__
BLEEDING GUMS__
BLISTER ON LIPS OR MOUTH__
BURNING SENSATION ON TOUNGE
CHEW ON ONE SIDE OF MOUTH__
CIGARETTE, PIPE, OR CIGAR SMOKING__
CLICKING OR POPPING JAW__
DRY MOUTH__
FINGERNAIL BITING__
SENSITIVITY TO COLD__
SENSITIVITY TO HOT __
SENSITIVITY TO SWEET__

FOOD IMPACTION__
GRINDING TEETH__
GUMS SWOLLEN OR TENDER__
JAW PAIN OR TIREDNESS__
LIP OR CHEEK BITING__
LOOSE TEETH OR BROKEN TEETH__
MOUTH BREATHING__
PAIN AROUND EAR__
ORTHODONTIC TREATMENT__
PERIODONTAL TREATMENT__
SORES/GROWTHS IN YOUR MOUTH__
SENSITIVITY WHEN BITING__

MARK I. GROSKIN DDS

Acknowledgement of Receipt of Notice of Privacy Practices

PURPOSE: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,_____ have received a copy of this offices notice of privacy practices.

_____(Please print name)

_____(Signature)

_____(date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An Emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

DR. Mark Groskin & Associates
1109 English Rd.
Rochester, NY 14616
585-225-7070

FINANCIAL POLICY

This is an agreement between Mark I. Groskin DDS & Associates and the patient named on this form. By executing this agreement, you are agreeing to pay for all services that are received for yourself and all immediate family members in your household, (this includes insurance payments of course!)

Payment options if you have no insurance: We currently offer a 20% discount to patients without insurance.

You choose to pay by __cash, __check, or __credit card on the day that treatment is rendered.

On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the balance at the time of the insert.

On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.

We offer special financing through Care Credit. The Care Credit plan is similar to a credit card. We will give you a 1-800 number to call, they'll ask you for some information, we'll tell them how much your treatment plan cost, and they will tell us if you're approved for a loan and you would make low monthly payments directly to them. If you're interested in Care Credit please ask Donna at the front desk.

WE DO NOT BILL OUT OF POCKET EXPENSES: THEY MUST BE PAID AT THE TIME OF SERVICE.

Payment options if you have insurance:

You choose to pay your deductible (if applicable) and any out-of-pocket portions at the time services are rendered by __cash, __check, or __credit card. (This option applies if Dr. Groskin participates with your insurance.)

You choose to pay all of your treatment by __cash, __check, or __credit card. We will request your insurance carrier send their payment directly to you. (This is mandatory if Dr. Groskin does NOT participate with your insurance).

On extensive treatment (crowns or bridges) you may choose to pay 50% of your out-of-pocket portion on the start or preparation date, and the balance on the completion or delivery date. (Normally three weeks later.)

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay; it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance insurance company.

Required payments: Any co-payments required by an insurance company must be paid at the time of

service. Because this is an insurance requirement, **we cannot bill you for these.**

Patients over the age of 18 are responsible for their account, unless we receive a written letter from parent.

Returned checks: There is a fee (currently $35) for any checks returned by the bank.

*****Missed appointment fee**:*** *If at any time a patient does not show up on time for an appointment, or cancels with* ***less than 48 hours notice, a $35 fee will be charged.*** *(Excluding emergency situations of course) This fee must be paid before a new appointment is scheduled.*

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. If your account is transferred to collections, we will have to dismiss you as a patient.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child (the parent who brings the child in for treatment) will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Not Dr. Groskin's office.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $15) if you want to have copies of your records sent to another doctor or organization.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions c By signing, you are stating that you have reviewed the financial policy, listed below, and agree to all terms and conditions contained herein:

PATIENT NAME: _____

RESPONSIBLE PARTY (If not the patient): _____

Please list all family members you are financially responsible for:

_____

Responsible Party Signature: _____ Date: _____

Co-Signature (Spouse): _____ Date: _____