MG2 DDS
Dr. Mack Greder II

7802 Davenport St, Omaha, NE. 68114
402-281-4238

OFFICE USE ONLY
Entered: _____
Verified: _____

PATIENT INFORMATION

PATIENT LEGAL NAME: _____ PREFERRED NAME: _____ DOB: ___/___/___
(PLEASE PRINT) (PLEASE PRINT)

HOME ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PHONE NUMBERS:
Cell (_ _ _) _ _ _ - _ _ _ _ Home (_ _ _) _ _ _ - _ _ _ _ Work (_ _ _) _ _ _ - _ _ _ _

EMAIL ADDRESS: _____ EMPLOYER/SCHOOL: _____

SOC SEC #: _ _ _ - _ _ - _ _ _ _ (ADULT ONLY) MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMERGENCY CONTACT: _____ PHONE NUMBER: (_ _ _) - _ _ _ - _ _ _ _

PERSON RESPONSIBLE FOR PAYING THE BILL **IF SAME AS ABOVE LEAVE BLANK

RESPONSIBLE PERSON: _____ BIRTH DATE: ___/___/___
(PLEASE PRINT)

ADDRESS OF RESPONSIBLE PERSON: _____ CITY: _____ STATE: ___ ZIP: _____

BIRTH DATE: ___/___/___ SOC SEC # _ _ _ - _ _ - _ _ _ _

PHONE NUMBERS:
Cell (_ _ _) _ _ _ - _ _ _ _ Home (_ _ _) _ _ _ - _ _ _ _ Work (_ _ _) _ _ _ - _ _ _ _

PRIMARY DENTAL INSURANCE INFORMATION

DENTAL INSURANCE COMPANY NAME: _____ SUBSCRIBER ID #: _____
GROUP #: _____

IF THE FOLLOWING INFORMATION IS DIFFERENT THAN THE PATIENT INFORMATION PLEASE FILL IN

EMPLOYER: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DATE OF BIRTH: ___/___/___

SOC SEC #: _ _ _ - _ _ - _ _ _ _ ** IF THERE IS NOT A SUBSCRIBER ID # ON THE INSURANCE CARD THE SOCIAL SECURITY # IS NEEDED TO FILE YOUR INSURANCE CLAIM**

SECONDARY DENTAL INSURANCE INFORMATION

DENTAL INSURANCE COMPANY NAME: _____ SUBSCRIBER ID #: _____
GROUP #: _____

IF THE FOLLOWING INFORMATION IS DIFFERENT THAN THE PATIENT INFORMATION PLEASE FILL IN

EMPLOYER: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DATE OF BIRTH: ___/___/___

SOC SEC #: _ _ _ - _ _ - _ _ _ _ ** IF THERE IS NOT A SUBSCRIBER ID # ON THE INSURANCE CARD THE SOCIAL SECURITY # IS NEEDED TO FILE YOUR INSURANCE CLAIM**

How did you hear about our office? ☐ Website ☐ Insurance ☐ Referral ☐ Other _____

** If referred, who can we thank for referring you? _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: ___/___/___

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NOTICE OF CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice. I have been informed of and given the right to review and secure a copy of your Notice of Privacy Practices.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for the delivery of proper dental care.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment provided for purpose of evaluation and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment to another dentist, or another healthcare professional and their staff.

FINANCIAL RESPONSIBILITY

- I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.
- I understand that my dentist and staff will estimate insurance benefits as close as possible. I understand that I am responsible for payment of the account and providing correct insurance information.
- I understand that if insurance is not applicable when dental services are rendered, then full payment is due at the time of service unless I have made other payment arrangements.

***** I understand failure to pay withing 30 days of receiving payment may result in a late payment charge of $15.00**

CANCELLATION POLICY

- If I am unable to make my scheduled appointment, I will give the office at least a 24 hour notice.
- I understand I may incur a fee of $25.00 if I "No Show" or fail to give at least a 24 hour notice of cancelling my scheduled appointment.

PATIENT NAME: _____ **DATE:** _____

PRINT PATIENT NAME

PATIENT SIGNATURE: _____

SIGNATURE OF PATIENT, PAREENT OR GUARDIAN

REVISED 03/03/2021

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Patient Legal Name: _____ **Preferred Name:** _____ **DOB:** __/__/__
(PLEASE PRINT) **(PLEASE PRINT)**

DENTAL HISTORY (CHECK YES or NO AS NEEDED)

HAVE YOU HAD OR ARE YOU HAVING ANY OF THE FOLLOWING?

Are your apprehensive about dental treatment? __YES __NO Are you aware of **grinding or clenching**? __YES __NO
Have you had **Periodontal** (gum) treatment? __YES __NO Do you have **frequent headaches**? __YES __NO
Do your **gums bleed**, **feel tender** or **irritated**? __YES __NO

When was your last dental cleaning and exam? _____
May we contact your previous dentist for records? __YES __NO If yes, DENTIST NAME: _____

PREMEDICATION PRIOR TO DENTAL TREATMENT

Have you ever been told to take an antibiotic premedication prior to dental treatment? __ YES __NO
If yes, what was the reason? ☐ **Joint Replacement** ☐ **Heart Valve** ☐ **Heart Murmur** ☐ **Other** _____
If yes, what medication do you premedicate with? ☐ **Amoxicillin** ☐ **Clindamycin** ☐ **Other** _____
PRESCRIBING DOCTOR: _____

MEDICAL HISTORY

Are you under a **PHYSICIANS CARE**? If yes, for what? __YES __NO _____
_____
PHYSICIAN'S NAME: _____
Have you been hospitalized or had a major operation? __YES __NO If yes _____
Have you had a serious head or neck injury? __YES __NO If yes _____
Are you taking any **MEDICATIONS, PILLS OR DRUGS**? **If yes, please list** __YES __ NO
_____
Do you use controlled substances? __ YES __NO If yes _____
Do you or have you taken, **Phen-Fen or Redux**? __YES __NO _____
Do you smoke/use tobacco? __YES __NO
Women, are you ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking an oral contraceptive

BLOOD THINNING MEDICATIONS

Are you taking **BLOOD THINNER** medication? __ YES __ NO
If yes, check which one:
☐ Warfarin ☐ Coumadin ☐ Eliquis ☐ Plavix
☐ Aspirin ☐ Other: _____
PRESCRIBING DOCTOR: _____

MEDICAL HISTORY CONTINUED

BONE BUILDING MEDICATION

Have you taken any **"BONE BUILDING"** medications? __YES __NO

If yes, please check which one/ones:

☐ Boniva ☐ Prolia ☐ Xgeva ☐ Reclast

☐ Zometa ☐ Actonel ☐ Medications that end with "MAB" ☐ Other_____

PRESCRIBING DOCTOR: _____

ALLERGIES

Please check any of the following that you are allergic to:

☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics

☐ Metal ☐ Penicillin ☐ Sulfa Drugs ☐ Other: Please list

MEDICAL CONDITIONS

☐ ACID REFLUX	☐ COLD SORES/FEVER BLISTERS	☐ LIVER DISEASE
☐ AIDS/HIV POSITIVE	☐ CONGENITAL HEART DISORDER	☐ MITRAL VALVE PROLAPSE
☐ ALZHEIMER'S DISEASE	☐ DIABETES	☐ OSTEOPOROSIS
☐ ANAPHYLAXIS	☐ EPILEPSY/SIEZURES	☐ RHEUMATISM
☐ ARTIFICIAL HEART VALVE	☐ HAY FEVER	☐ RHEUMATIC FEVER
☐ ARTIFICIAL JOINT	☐ HEART DISEASE	☐ SCARLET FEVER
☐ ASTHMA	☐ HEART MURMUR	☐ STOMACH/INTESTINAL DISEASE
☐ BLOOD DISEASE	☐ HEART PACEMAKER	☐ STROKE
☐ BLOOD TRANSFUSION	☐ HEPATITIS A, B OR C	☐ THYROID DISEASE
☐ BREATHING PROBLEMS	☐ HIGH/LOW BLOOD PRESSURE	☐ TUBERCULOSIS
☐ BRUISE EASILY	☐ HIGH CHOLESTEROL	☐ OTHER
☐ CANCER/CHEMOTHERAPY/RADIATION	☐ KIDNEY PROBLEMS	

The undersigned hereby attests that the information is complete and accurate.

_____ _____

PRINT PATIENT NAME **SIGNATURE of PATIENT, PARENT OR GUARDIAN**

_____

DATE

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Entered: ___
Reviewed____