

**Taylorsville Family Dentistry  
Dr. Boone Groce DMD  
311 Hwy 16 South  
Taylorsville, NC 28681**

Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_M\_\_\_F Age \_\_\_\_\_ Date Of Birth \_\_\_\_\_  
Last First MI

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Minor \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Partnered \_\_\_\_\_

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

**Primary Insurance**

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient? \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Insurance ID: \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_

**\*\*WHEN FILING INSURANCE THE SOCIAL SECURITY NUMBER & DATE OF BIRTH OF THE POLICY HOLDER ARE REQUIRED\*\***

**Assignment and Release**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Boone Groce all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature/Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Dental History**

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

**Please mark (X) to indicate if you have had any of the following**

Bad Breath _____	Grinding teeth _____	Pain around ear _____
Bleeding Gums _____	Gums swollen or tender _____	Periodontal treatment _____
Cold Sores/Fever Blisters _____	Jaw pain or tenderness _____	Sensitivity to cold _____
Burning sensation on tongue _____	Lip or cheek tenderness _____	Sensitivity to sweets _____
Smokeless tobacco use(chew/dip) _____	Loose teeth or broken filling _____	Sensitivity to heat _____
Cigarette, pipe, or cigar smoking _____	Dry mouth _____	Mouth breathing _____
Sensitivity when biting _____	Fingernail biting _____	Mouth pain, brushing _____
Sores or growths in mouth _____	Food collection between teeth _____	Orthodontic treatment _____

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Do you take, or have you taken, any of the following medications: Phen-Fen or Redux, Adipex, Fastin, \_\_\_Yes \_\_\_No  
\*If Yes \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? \_\_\_Yes \_\_\_No  
\*If Yes \_\_\_\_\_

Are you on a special diet? \_\_\_Yes \_\_\_No \*If Yes \_\_\_\_\_

Do you use controlled substances? \_\_\_Yes \_\_\_No \*If Yes \_\_\_\_\_

### Do you have, or have you had, any of the following:

AIDS/HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cortisone Medicine	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hemophilia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Radiation Treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO
Alzheimer's Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis A	<input type="checkbox"/> YES <input type="checkbox"/> NO	Renal Dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Drug Addiction	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis B or C	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Angina	<input type="checkbox"/> YES <input type="checkbox"/> NO	Easily Winded	<input type="checkbox"/> YES <input type="checkbox"/> NO	Herpes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Scarlet Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis/Gout	<input type="checkbox"/> YES <input type="checkbox"/> NO	Emphysema	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shingles	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Heart Valve	<input type="checkbox"/> YES <input type="checkbox"/> NO	Epilepsy or Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Cholesterol	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sickle Cell Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Joints	<input type="checkbox"/> YES <input type="checkbox"/> NO	Excessive Bleeding	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hives or Rash	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sinus Trouble	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Excessive Thirst	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hypoglycemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Spina Bifida	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting/Dizziness	<input type="checkbox"/> YES <input type="checkbox"/> NO	Irregular Heartbeat	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stomach Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Transfusion	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Cough	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Intestinal Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Breathing Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Diarrhea	<input type="checkbox"/> YES <input type="checkbox"/> NO	Leukemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bruise Easily	<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Swelling of Limbs	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	Genital Herpes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Low Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chemotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Lung Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tonsillitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chest Pains	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hay Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mitral Valve Prolapse	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Convulsions	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Attack/Failure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Osteoporosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tumors/Growths	<input type="checkbox"/> YES <input type="checkbox"/> NO
Congenital Heart Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Murmur	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pain in Jaw Joints	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ulcers	<input type="checkbox"/> YES <input type="checkbox"/> NO
		Heart Pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO	Psychiatric Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yellow Jaundice	<input type="checkbox"/> YES <input type="checkbox"/> NO

Have you had any serious illness not listed above: YES NO \*If Yes \_\_\_\_\_

### **Women Only:**

Are you pregnant? \_\_\_Yes \_\_\_No Due Date \_\_\_\_\_ Are you nursing? \_\_\_Yes \_\_\_No Taking birth control? \_\_\_Yes \_\_\_No

### **Medications**

Please list any medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Allergies**

Are you allergic to any of the following:

Aspirin \_\_\_\_\_ Local Anesthetic \_\_\_\_\_  
 Barbiturates \_\_\_\_\_ Penicillin \_\_\_\_\_  
 Codeine \_\_\_\_\_ Sulfa \_\_\_\_\_  
 Latex \_\_\_\_\_  
 Other (Please Specify): \_\_\_\_\_

Preferred Pharmacy Name \_\_\_\_\_ Phone: \_\_\_\_\_

### **Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact #: \_\_\_\_\_ Other #: \_\_\_\_\_

# AUTHORIZATION TO RELEASE HEALTH INFORMATION

*Communications between Patients and their Families, Friends, or Caregivers*

This form allows Taylorville Family Dentistry/Dr. Boone Groce to communicate information about your care (i.e. appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

**Patient Name:** \_\_\_\_\_  
(Last) (First) (Middle Initial)

**Date of Birth:** \_\_\_\_\_ **Main Contact Number:** (\_\_\_\_\_) \_\_\_\_\_  
mm/dd/yyyy  Home  Cell\*  Work

**Mailing Address:** \_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City) (State) (Zip)

## COMMUNICATING WITH YOU

### PHONE

- Main Contact Number Above  
 Other: (\_\_\_\_\_) \_\_\_\_\_  
 Home  Cell\*  Work

### DETAILED MESSAGES PERMITTED

- text (SMS)\*  voicemail/answering machine  None  
 text (SMS)\*  voicemail/answering machine  None

### EMAIL\*

- \_\_\_\_\_  
 All information from this practice  Data breach notifications  
 Appointment information only (request/confirm/cancel)  Billing/insurance information

## COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

- This practice may communicate to the family members, friends, or caregivers listed below.

Name: \_\_\_\_\_  
First and Last Name  
Phone: (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Name: \_\_\_\_\_  
First and Last Name  
Phone: (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Check the box next to each type of information this practice may share.

- All information  Prescriptions  Appointments (request/confirm/cancel)  Billing/Insurance  
 Other: \_\_\_\_\_

\* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.  
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

---

## PATIENT RIGHTS & SIGNATURE

---

- I understand that I have certain rights regarding my protected 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, obtaining payment from third party payers (i.e. insurance company), and the day to day healthcare operations of the practice.*
- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.
- I have also been given the right to review and secure a copy of your Notice of Privacy Practices, which is a description of the uses and disclosures of my protected health information, and my rights under HIPAA

---

Patient/Personal Representative Signature

Date: mm/dd/yyyy

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)  
(Attach documentation to support the personal representative's authority if not already on file with the practice)

---

---

### FOR OFFICE USE & REFERENCE ONLY

This authorization has been terminated: \_\_\_\_\_

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: \_\_\_\_\_

Copy of original authorization provided to patient/personal representative (check if yes)

Notes: \_\_\_\_\_

---

---

It is recommended that the practice review this form with the patient or their personal representative periodically for changes (e.g., annually with insurance verification).

# Taylorsville Family Dentistry | Boone H Groce, DMD

## Office Scheduling Policy

Taylorsville Family Dentistry may call/text my home/workplace/cell to confirm future appointments and may leave a message on my answering machine or voice mail.

- In order to be able to see our patients in a timely manner and respect their time, we must have a confirmation of your appointment at least 24 hours in advance of the appointment time. All cancellations will require at least 24 hours' notice. In the unforeseen event that the office is running behind, a courtesy call will be made to the patient, so they may reschedule their day, if they desire, to reschedule their appointment should the time change create a problem.
- After 3, same day cancellation/no-shows/missed appointments, patient will be considered a 'same day only' patient, meaning we will only be able to schedule an appointment for the day patient calls in, if the office has the availability to see the patient.
- **Friday Appts:** Friday appointments are very valuable due to the fact that most dental offices are closed on Fridays. We try to accommodate our patients by opening one Friday a month. However, due to the high frequency of No-show appointments, we have implemented a new policy. Appointments that are missed *on Fridays*, without a 24 hr notice, will incur a \$100 balance that will have to be paid before that appointment can be rescheduled. We regret to enforce this policy, but it will better ensure that our patients who need and want to be seen, will have the opportunity to do so.

## Financial Policy Agreement

Our office wants to do all that we can do to make high quality dental care affordable to you and your family. We have prepared this to help you better understand the complexities of dental insurance; we realize how confusing it can be.

**For patients without insurance:** Our office accepts cash, check, Visa, Discover, MasterCard, and American Express. We do offer an out of pocket discount for those without insurance. We also participate in Care Credit. To learn more about this program visit [www.carecredit.com](http://www.carecredit.com).

**For patients with insurance:** You must provide our office with a current insurance card and all information necessary to verify your coverage and file your claim efficiently. While we strive to provide you with the best **estimate** possible for your portion of the payment, insurance reimbursements may vary slightly from what we have predicted. Your insurance company allows or considers fees "usual, customary, and reasonable" all of which vary from one company to another. They have nothing to do with the actual fee for services rendered.

- Our fees are based upon a combination of our cost, our time, and our consistent dedication to providing our patients with the highest quality of dental care. Please understand, **dental insurance is not designed to pay for all of your dental care, therefore, any discrepancy between insurance payment and our fees, is the patient's responsibility.**
- If another office has filed or will be filing claims associated with work you have received there (e.g. oral surgeon or other specialist), you may exceed the maximum benefit of your insurance provider without our knowledge. In other words, the insurance payment could be denied to our office or dental payment could be less than estimated.
- It should be understood that the **dental insurance contract is between the insurance company and the patient.** If you are unclear as to whether a particular procedure is covered by your carrier, we can submit a pre-estimate for treatment before scheduling.

---

Patient/Personal Representative Signature

---

Date: mm/dd/yyyy