Appointment Itinerary

Green Gregson Family Dentistry
(504) 849-0190 | info@greengregsondds.com

We look forward to meeting you and providing excellent care for you. Taking the steps outlined below will help to utilize time on the day of your appointment.

- ❑ Please bring completed forms with you, or email them to us at info@greengregsondds.com before your scheduled appointment.
- ❑ Please bring a dental insurance card and a valid ID or driver's license.
- ❑ Please bring with you a list of all current medications.
- ❑ Please bring previous dental records or any information to help us obtain them.
  - ❑ Please ask your current or previous dental office to email your records and/or digital x-rays to info@greengregsondds.com.
  - ❑ If you have a history of periodontal treatments (deep cleanings), we will need a date of the "deep cleaning" for insurance purposes. Please let us know if you have had this procedure done in the past so we can schedule accordingly.

Scheduling and Payments

Please be aware that our office collects all fees (co-pays, coinsurance and/or other fees) due at time of service.

We respectfully ask for scheduled appointments to be canceled at least 24 hours in advance. For appointments that are not canceled a minimum of 24 hours in advance; we will apply a fee of $50 per scheduled hour.

Office Location & Directions

Our office is located in Metairie at the corner of Ridgelake and 6th St near the foot of the Causeway bridge. For directions to our office, please visit our website, greengregsondds.com.

Contact Information

If you have any questions please call, text, or email us and we would be delighted to help.

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Office Policies

Green Gregson Family Dentistry
(504) 849-0190 | info@greengregsondds.com

Please read carefully and initial on the line next to each paragraph, sign and date.

PAYMENT OPTIONS

_______ Green Gregson Family Dentistry requires payment at the time of service. We accept: Cash, Check, Visa, MC, Amex, Discover and Care Credit. A $35 fee will be charged for all returned NSF checks.

INSURANCE

_______ We are in network with four insurance companies. They are: **SUNLIFE, AETNA, CIGNA, UNITED CONCORDIA (ALLIANCE NETWORK ONLY).** Insurance will be applied to your visit and you, the patient, will be responsible for the remaining balance.

_______ You are responsible for all payments due to Green Gregson Family Dentistry. Insurance plans are a contract between the patient and the insurance provider. It is the patient's responsibility to know their benefit plan. As a courtesy for our patients, we are happy to help you understand the limitations of your plan. Green Gregson Family Dentistry will handle your claims for a maximum of 60 days. If we have not received a response from your insurance provider after 60 days, any further handling becomes the patient's responsibility at which time payment will be due in full. Additionally, all treatment plans provided by Green Gregson Family Dentistry are estimated insurance coverage, not a guarantee by the insurance provider.

APPOINTMENTS

_______ Appointments are made in advance by reserving a room and time specifically for you. We try very hard not to keep our patients waiting. Because we respect your time so much, we ask that you respect ours by calling a **minimum of 48 hours in advance to cancel or reschedule your appointment** so we can give that valuable time to another patient in need. This policy enables us to accommodate all of our patients, but ensuring that our limited hours during the work day are not unused. We reserve the right to charge a patient's account $50 per scheduled hour if we do not receive a minimum of 48 hour notice to cancel or reschedule appointment. After three last minute cancellations or failed appointments, we reserve the right to refuse any further services.

_______ Due to our scheduling, we reserve the right to consider any patient who appears 15 minutes late to his or her scheduled appointment as a "no show." Late arrival for a scheduled appointment leads to inadequate time for your treatment as well as inconvenience to the next scheduled patient.

______________________________________ ______________________________
Patient or Parent/Guardian Signature Date

____
Patient Name (Please Print)

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Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask and we will be happy to help.

Name (Full)____Preferred Name______________________

Address____City_____________State_____Zip__________

Home #______________________Work #______________________Cell #______________________

Birthdate_________________SSN_____________________E-mail:____________________________

Check which one is appropriate?
____Single ____Married ____Divorced ___Widowed ___Separated

If a student, circle FULL or PART-TIME. Name of School___________________________________City____________________State______________

Patient or Parent's Employer __________________________________Work #__________________

Spouse Name_____________________Employer________________Work #____________________

Person to contact in case of emergency______________________Relationship__________________Phone #_________________

Who referred you (How did you hear about us?) _____________________________________

Responsible Party (IF OTHER THAN SELF)

Person Responsible for Account____________________________Relationship____________________

Address____Home #________________________

Signature____SSN__________________________

Dental Insurance Information

Policy Holder__________________________Birthdate_______________Relationship______________

Name of Employer________________________________City_____________________State________

Insurance Company__________________________________Group #___________________________

Policy Holder SSN__________________________Policy Holder Member ID#_____________________

*****Please Notify Receptionist if you have Secondary Dental Insurance*****

I agree that this signature indicates that the above information is accurate.

Signature of Patient___________________________________**Date**______________________

Dr. Randolph D. Green
Dr. Jeffrey M. Gregson

Medical History

PATIENT NAME________________________________DOB_____________DATE_____________

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.

Are you under a physician's care now? If yes, explain______________________________________
Have you ever been hospitalized/ had major operation? If yes, explain__________________________
Have you ever had a serious head/neck injury? If yes, explain_________________________________
Are you taking any medications? If so, list here

____
Do you use tobacco? ______________________ Are you on a special diet? __________________________
Have you taken Bisphosphonate drugs (such as Fosamax)? If yes, IV or Oral, explain_________________
Do you use controlled substances? If yes, explain_______________________________________
Women are you: ____Pregnant/Trying to get pregnant? ____Nursing? ____Taking oral contraceptives?

Are you allergic to any of the following? ____Aspirin ____Penicillin ____Local Anesthetics
____Acrylic ____Metal ____Latex ____Codeine____Sulfa____Other, list here________________

Please check any of the following that you have, or have had:

____AIDS/HIV Positive
____Alzheimer's Disease
____Anaphylaxis
____Anemia
____Angina Arthritis/Gout
____Artificial Heart Valve
____Artificial Joint
____Asthma
____Blood Disease
____Blood Transfusion
____Breathing Problem
____Bruise Easily
____Cancer
____Chemotherapy
____Chest Pains
____Cold Sores/Fever Blisters
____Congenital Heart Disorder
____Convulsions
____Cortisone Medicine

____Diabetes
____Drug Addiction
____Easily Winded
____Emphysema
____Epilepsy/ Seizures
____Excessive Bleeding
____Excessive Thirst
____Fainting Spells/Dizziness
____Frequent Cough
____Frequent Diarrhea
____Frequent Headaches
____Genital Herpes
____Glaucoma
____Hay Fever
____Heart Attack/Failure
____ Heart Murmur
____Heart Pace Maker
____Heart Trouble/Disease
____Hemophilia

____High Cholesterol
____Hepatitis A
____Hepatitis B/C
____Herpes
____High Blood Pressure
____Hives/Rash
____Hypoglycemia
____Irregular Heartbeat
____Kidney Problems
____Leukemia
____Liver Disease
____Low Blood Pressure
____Lung Disease
____Mitral Valve Prolapse
____Pain in Jaw Joints
____Parathyroid Disease
____Psychiatric Care
____Radiation Treatment
____Recent Weight Loss
____Renal Dialysis

____Osteoporosis
____Rheumatic Fever
____Rheumatism
____Scarlet Fever
____Shingles
____Sickle Cell Disease
____Sinus Trouble
____Spina Bifida
____Stomach/Intestinal Disease
____ Stroke
____Swelling of Limbs
____Thyroid Disease
____Tonsillitis
____Tuberculosis
____Tumors or Growths
____Ulcers
____Venereal Disease
____Yellow Jaundice

Have you ever had a serious illness not listed? Explain:
____

Dental History

Have you received any recent dental treatment? If yes, what, when, & where?
____
Do you have anxiety about your dental visit? If yes, explain ________________________________
Are you happy with your smile? If no, explain____
Do you have any TMJ pain or problems? If yes, explain ______________________________
WHAT IS YOUR **MAIN DENTAL CONCERN?** _________________________________
Comments: ____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status as they occur.
Signature of Patient____**Date**________________

Dr. Randolph D. Green / Dr. Jeffrey M. Gregson

Dr. Randolph D. Green / Dr. Jeffrey Gregson
3812 Ridgelake Drive, Suite 300, Metairie, Louisiana 70002

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT GIVING CONSENT- PLEASE READ FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, insurance claims, and healthcare operations.

Notice of Privacy Practices: You have received and have had the opportunity to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Randolph D. Green / Dr. Jeffrey M. Gregson
Address: 3812 Ridgelake Drive, Suite 300, Metairie, Louisiana 70002
Phone: (504) 849-0190
Fax: (504) 849-0192

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Persons listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature Below Acknowledges Receipt of Notice of Privacy Practices and Consent for the Use and Disclosure of Your Health Information:

I, (Please Print Name)____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: ____Date: ___________________________

If a personal representative on behalf of the patient signs this Consent, complete the following:
Representative's Name: _________________________________Relationship to Patient: _______________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledge 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)______________________________