

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 your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Patient # _____
SS#/SIN _____
Date _____
Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE?

☐ Yes

☐ No

IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | | | | | |
|----------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you wearing contact lenses?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... | <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you allergic to or have you had any reactions to the following? | | |
| If yes, please explain | | | Local Anesthetics (e.g. Novocain) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking? | | | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?..... | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | <input type="checkbox"/> | <input type="checkbox"/> | Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (e.g. nickel, mercury, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have or have you had any of the following? | | | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other (please list) | | |
| | | | 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 13. Women Only: | | |
| | | | a) Are you pregnant or think you may be pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b) Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c) Are you taking oral contraceptives?..... | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No | | Yes | No | | Yes | No |
|-----------------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| High Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack..... | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker..... | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur..... | <input type="checkbox"/> | <input type="checkbox"/> | Stroke..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles..... | <input type="checkbox"/> | <input type="checkbox"/> | Angina..... | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever / Allergies..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures..... | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired..... | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma..... | <input type="checkbox"/> | <input type="checkbox"/> | Anemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema..... | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions..... | <input type="checkbox"/> | <input type="checkbox"/> | Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases..... | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis / Jaundice..... | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection..... | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem..... | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles / Ulcers..... | <input type="checkbox"/> | <input type="checkbox"/> | Other..... | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|-------------------------------------------------------------------------|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Do you wear dentures or partials? | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking | <input type="checkbox"/> | <input type="checkbox"/> | If yes, date of placement | | |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. 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 authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (or parent/guardian if minor) _____ Date _____

Doctor's Comments _____

Signature _____ Date _____

**Acknowledgement of Receipt of Notice of Privacy Practices
Garrisonville Dental**

Patient Name & Address:

I have received a copy of the Notice of Privacy Practices.

Signature	Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

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- ☐ Other:

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Prepared by:	
Signature:	
Date:	

Authorization for Release of Information – Compound Release

Patient Name: _____	
Patient Date of Birth: _____	
The office of Garrisonville Dental is authorized to release protected health information as described below for the identified patient.	
Entity to Receive Information. Check each person or class of persons that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Messages on _____ number.	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Other
<input type="checkbox"/> Spouse or Significant Other: _____	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Treatment Notes and Record <input type="checkbox"/> Discuss Treatment
<input type="checkbox"/> Other Person: _____	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Treatment Notes and Record <input type="checkbox"/> Discuss Treatment
<input type="checkbox"/> Other Person: _____	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Treatment Notes and Record <input type="checkbox"/> Discuss Treatment
Patient Rights: <ol style="list-style-type: none">1. I have the right to revoke this authorization at any time.2. I may inspect or copy the protected health information to be disclosed as described in this document.3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.	
This authorization will remain in effect until I revoke it in writing, or on the date listed below:	
Signature of Patient or Personal Representative _____	Date: _____
Description of Personal Representative's Authority (attach necessary documentation) : <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian	
Date this Authorization Expires: _____	



Garrisonville Dental

Consent to Dental Treatment

I, (print name) _____, hereby give **Garrisonville Dental** my consent to perform dental treatment considered necessary.

I understand that as the treatment proceeds there may be need to change the treatment plan. If this occurs, I expect to be informed before any change is instituted.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible. I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

When treatment plans are presented, the expected insurance payment is an estimate. If for any reason the Insurance Company does not pay the amount estimated, I will be responsible for the difference.

In order for us to collect any amounts you may owe us, you authorize us and our affiliates which include debt collectors, to contact you at any telephone number associated with your account. Methods of contact may include the use of automatic telephone dialing systems and automated SMS text message reminders.

As a courtesy, we will file a claim for you. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. If insurance has not paid claim within 90 days, patient is responsible to pay for services rendered and then reimbursed when insurance payment is received.

Payment for services is expected at the time service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. If an extended payment plan is desired, please ask us about the CareCredit program.

We reserve a specific block of time for each of our patients. An appointment with you is a bond of trust that we will be here to serve you. We expect you to be present for each of your appointments. It is extremely difficult to provide you with the kind of treatment that you expect from us with constant short notice changes on our schedule. As a result, we charge \$50 per hour for all cancellations made less than 24 hours in advance.

x _____

Patient Signature If a minor, Signature of Parent or Guardian

Date _____

