Gardner Springs
DENTISTRY
Sedation · Implant · Cosmetic

PATIENT INFORMATION:

FIRST NAME:_____ LAST NAME:_____

PREFERRED NAME:_____ DOB:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

CELL PHONE:_____ WORK PHONE:_____

EMAIL ADDRESS:_____

EMPLOYER:_____ OCCUPATION:_____

SINGLE ☐ MARRIED ☐ STUDENT ☐ OTHER:_____

EMERGENCY CONTACT:

NAME/PHONE#:_____ RELATIONSHIP:_____

Whom may we thank for your referral?_____

_____

DENTAL INSURANCE:

SUBSCRIBER'S NAME:_____ PHONE#:_____

DOB:_____ SSN:_____-_____-_____ EMPLOYER:_____

INSURANCE CARRIER:_____ MEMBER ID#:_____

GROUP#_____ INSURANCE PHONE#:_____

DENTAL HISTORY:

What is the reason for your visit today?_____

Approximate date of last dental exam, cleaning, & x-rays:_____

How often do you typically have your teeth cleaned?_____

How often do you floss?_____How often do you brush your teeth?_____

Do you use a WaterPik or Water Flosser? ☐ YES ☐ NO

PREVIOUS DENTAL OFFICE/ DENTIST:_____

Now or in the past, have you ever used/had:

- ☐ Sensitivity to temperature
- ☐ Sensitivity to chewing
- ☐ Gum treatment or surgery
- ☐ Food catching between teeth
- ☐ Family history of oral cancer
- ☐ Canker sores/Ulcers
- ☐ Clench or Grind teeth
- ☐ Jaw clicking/popping/ locking
- ☐ Headaches
- ☐ Dental sedation
- ☐ Retainer
- ☐ Nightguard
- ☐ Dry Mouth
- ☐ Botox treatment
- ☐ Loose teeth
- ☐ Teeth Whitening
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Periodontal Disease
- ☐ Dental Implants
- ☐ Orthodontic treatment

What would you like us to change about your smile?

_____

Do you feel nervous at the Dental Office? ☐ YES ☐ NO

Would you prefer to be awake or asleep for your dental treatment? _____

Is there anything we could do to make your dental experience more comfortable?

_____

Are you interested in learning more about the following?

- ☐ Invisalign
- ☐ Dental Implants
- ☐ Cosmetic Dentistry
- ☐ Teeth Whitening
- ☐ Sedation Dentistry
- ☐ Headache relief
- ☐ Missing tooth replacement
- ☐ TMJ Appliance
- ☐ Botox Treatment

Other:_____

MEDICAL INFORMATION:

TREATING MEDICAL PROVIDER:

NAME:_____PHONE#:_____

PHARMACY NAME/ADDRESS:_____PHONE#:_____

Have you been admitted to a hospital, had surgery, or needed emergency care in the past two years? ☐ YES ☐ NO

*If yes, please explain:*_____

Have you had or been treated for any of the following:

- ☐ Angina/ Chest Pain
- ☐ Blood Clot
- ☐ Congestive Heart Failure
- ☐ Congenital Heart Lesion
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ TIA (Mini-Stroke)
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Respiratory Problems
- ☐ Sleep Apnea
- ☐ Sinus Problems/ Surgery
- ☐ Autism/ Spectrum
- ☐ ADHD
- ☐ Dementia/ Alzheimer's
- ☐ Dizziness/ Fainting
- ☐ Epilepsy/ Seizures
- ☐ Gait Disturbances
- ☐ Migraines/ Headaches
- ☐ Neurological Disorders
- ☐ Parkinson's Disease
- ☐ Anxiety
- ☐ Depression
- ☐ Diabetes - Type:_____
- ☐ Thyroid Problems
- ☐ Peptides/ GLP-1 Agonists
- ☐ Hormone Replacement Therapy (HRT)
- ☐ Stomach Problems/GERD
- ☐ Stomach Ulcers/ Colitis
- ☐ Liver Disease
- ☐ Abnormal Bleeding
- ☐ Organ transplant
- ☐ Anemia
- ☐ Immunosuppression
- ☐ Hepatitis - Type:_____
- ☐ HIV/ AIDS
- ☐ Lyme Disease
- ☐ Arthritis
- ☐ Artificial Joint(s) - Which:_____
- ☐ Osteoporosis
- ☐ Cancer - Type:_____
- ☐ Chemotherapy/ Radiation
- ☐ Kidney Disease
- ☐ Glaucoma/ Eye Disorders
- ☐ Hearing difficulties
- ☐ Chronic Skin Rashes/

☐ Alcohol? - How often:_____ Do you have a pacemaker? ☐ YES ☐ NO

☐ Tobacco/Nicotine? - How often:_____ Type:_____

☐ Recreational Drugs? - Type:_____

*Female Patients: ☐ *Pregnant?* ☐ *Nursing?* ☐ *Taking Birth Control? - Type:*_____ ☐ *Menopause?*

Please list any prescription medications and over the counter supplements you are taking:

_____

_____

Are you allergic to any of the following:

- ☐ Penicillin
- ☐ Acetaminophen(Tylenol)
- ☐ NSAID's(Ibuprofen, Aspirin)
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Food:_____
- ☐ Sulfa
- ☐ Codeine/Hydrocodone

Other Allergies:_____

Patient Signature:_____**Date:**_____Provider:_____

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance. Necessary forms will be completed to help expedite insurance carrier payments as a courtesy to you. However, you are responsible for all fees, regardless of insurance coverage.

Initial:_____

***Assignment of Benefits** (If Insured)*

I hereby assign all dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment checks directly to *Gardner Springs Dentistry* for dental services rendered to myself and/or my dependent(s) regardless of my insurance benefits, if any. I understand that *Gardner Springs Dentistry* will provide an estimate of insurance coverage upon request. I understand that *Gardner Springs Dentistry* is not responsible for inaccurate estimates. Payment of a dental claim is not guaranteed by any insurance based on eligibility and policy coverage at the time a claim is submitted. ***I understand that I am responsible for any amount not covered by insurance and I agree to pay any balance amount in a timely manner.***

Initial:_____

***Authorization to Release Information** (If insured)*

I hereby authorize *Gardner Springs Dentistry* to furnish and/or release any information necessary to insurance carriers concerning my and/or my dependent(s) examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim(s). This order will remain in effect until revoked by me in writing.

Initial:_____

I, _____, have requested dental services from *Gardner Springs Dentistry* on behalf of myself and/or my dependent(s), and understand that by making this request, I become fully financially responsible for any and all charges incurred during the course of treatment. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Responsible Party Signature **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM:

I acknowledge that I have had the opportunity to receive a copy of the Notice of privacy Practices HIPAA Consent and agree to all provisions outlined herein and I give permission to *Gardner Springs Dentistry* to obtain information from my health record.

_____ _____

Signature of Patient **Date**

HEALTH INFORMATION DISCLOSURE:

I authorize the disclosure of my protected health information to the person(s) listed below:

NAME:_____ NAME:_____

PHONE#:_____ PHONE#:_____

RELATIONSHIP: RELATIONSHIP:

☐ SPOUSE ☐ PARTNER ☐ SIBLING ☐ SPOUSE ☐ PARTNER ☐ SIBLING

☐ PARENT ☐ CHILD ☐ FRIEND ☐ PARENT ☐ CHILD ☐ FRIEND

OTHER:_____

CREDIT CARD NOTICE:

I understand that *all credit card transactions will incur a 3% surcharge.* To avoid this additional fee, debit cards, checks, and cash are also accepted as payment options.

_____ _____

Signature of Patient **Date**

TEXT MESSAGING AND EMAIL CONSENT:

Gardner Springs Dentistry **offers HIPPA- compliant messaging by email and/or text messages for appointment confirmation and reminders, as well as other important notifications from our practice that impact you. However, your consent is required for us to provide this service. To that end, please read the disclaimer below, then sign, and check the appropriate box opting in or out of this service.**

I consent to Gardner Springs Dentistry contacting me by text messages and/or email. I understand that where text messaging is concerned, standard text messaging rates may apply. Furthermore, I understand that I can opt out of the text and/or email functions at any time.

☐ I choose to opt in to receive text and email messages and reminders

☐ I choose to opt out of receiving text and email messages and reminders

_____ _____

Signature of Patient **Date**

_____

Printed Name

CANCELLATION POLICY:

Gardner Springs Dentistry **makes an effort to see patients on time in order to give patients the care they deserve. Therefore, we require that you give 48 hours notice if you are unable to keep your scheduled appointment, otherwise we reserve the right to charge a cancellation fee of $50.00. We will make exceptions in the event of reasonable emergencies.** ***I understand and agree:***

_____ _____

Signature of Patient **Date**