Gardner Springs
DENTISTRY
Sedation · Implant · Cosmetic

Patient Information:

Patient's Last Name_____ First Name_____ Middle Initial_____

Preferred Name_____ Birth Date_____ Social Security #_____-_____-_____

Home Address_____ City/State_____ Zip_____

Cell Phone_____ Home Phone_____ Work Phone_____

E-Mail Address _____

☐Single ☐Married ☐Widowed ☐Divorced ☐Other _____

Emergency Contact Name/ Phone_____ Relationship _____

Whom may we thank for your referral? _____

What are some of your favorite things (hobbies, candy, sports, etc.): _____

Dental Insurance *(if applicable)*:

Subscriber's Name: _____ Relationship_____

Birthdate: _____/_____/_____ SSN# _____-_____-_____ Employer: _____

Insurance Carrier: _____ Insurance ID#_____ Group#: _____

Dental History:

What is the reason for your visit today? _____

Date of last Cleaning _____ Date X-rays last taken_____

Previous Dentist Name and Phone#_____

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

- ☐ Sensitivity to cold or hot
- ☐ Sensitivity to chewing
- ☐ Gum treatment or Surgery
- ☐ Food catching between teeth
- ☐ Canker Sores /Ulcers
- ☐ Clench or Grind Teeth
- ☐ Jaw clicking or popping
- ☐ Tension Headaches
- ☐ Wear a retainer
- ☐ Wear a night-guard
- ☐ Dry Mouth
- ☐ Chew Ice
- ☐ Loose teeth
- ☐ Whitening products
- ☐ Bad Breath
- ☐ Family History Oral Cancer

How often do you have dental examinations? _____How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you like the appearance of your smile?	☐Yes	☐No
Do you consider yourself a nervous dental patient?	☐Yes	☐No
Have you ever had an unpleasant dental experience?	☐Yes	☐No
Is there anything else about having dental treatment that you would like us to know?	☐Yes	☐No
Do you use an electric toothbrush?	☐Yes	☐No

*Are you interested in **information** on any of these topics:*

- ☐ Invisalign Orthodontics
- ☐ Teeth Whitening
- ☐ Replacing missing teeth
- ☐ Dental Implants
- ☐ Sedation Dentistry
- ☐ TMJ Appliance
- ☐ Facial Esthetics – Botox
- ☐ Cosmetic Dentistry
- ☐ Other: _____

Medical Information:

Name and Phone # of Treating Medical Provider: _____

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 ever had any of the following:

- ☐ Allergies
- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ ALS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint(s) Type and Year: _____
- ☐ Asthma
- ☐ Blood Clot
- ☐ Cancer Type: _____
- ☐ Dementia or Alzheimer's
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness or Fainting
- ☐ History of Drug Abuse
- ☐ Emotional Problems
- ☐ Epilepsy or Seizures
- ☐ Skin rashes
- ☐ Glaucoma/Eye Disorders
- ☐ Hearing Difficulties
- ☐ Hepatitis – Type: _____
- ☐ HIV/AIDS
- ☐ Immunosuppressive Disorders
- ☐ Kidney Disease
- ☐ Liver Disease or Jaundice
- ☐ Lyme Disease
- ☐ Migraines/ Headaches
- ☐ Menopause
- ☐ Neurological Disorders
- ☐ Osteoporosis
- ☐ Panic Attacks/Anxiety
- ☐ Parkinson's Disease
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems/GERD
- ☐ Stomach Ulcer/Colitis
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Use Type & Amount: _____
- ☐ Venereal Disease/ STD
- ☐ Alcohol Use? How Much: _____
- ☐ Bacterial Endocarditis
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Low Blood Pressure
- ☐ Artificial Heart Valve(s)
- ☐ Congenital Heart Lesion
- ☐ Mitral Valve Prolapse
- ☐ Heart Attack Year: _____
- ☐ Angina/Chest Pain
- ☐ Pacemaker
- ☐ Heart Surgery
- ☐ Congestive Heart Failure
- ☐ Rheumatic Fever

Women: Are you:

☐Pregnant/Trying to get pregnant? ☐Nursing? ☐Taking oral contraceptives?

Are you allergic to any of the following:

- ☐ Penicillin
- ☐ Acetaminophen
- ☐ NSAID's
- ☐ Codeine/Hydrocodone
- ☐ Latex
- ☐ Local anesthetics (Lidocaine)
- ☐ Metals
- ☐ Sulfa
- ☐ Seasonal (dust, pollen, dander)
- ☐ Food: _____
- ☐ Other _____

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

_____

_____

Authorizations:

I authorize release of information to all of my insurance companies.
I agree to pay for services rendered at the time of treatment.
I agree that I am ultimately responsible for my bill.
I authorize Dr. Gardner and her team to act as my agent in helping me to obtain payment from my Insurance companies.
I authorize payment directly to my doctor, Brandon Gardner, DD.S.
I consent to all necessary dental procedures as deemed appropriate by Dr. Gardner and his team.

Patient/ Parent Signature _____ Date: _____

Staff Use Only:

Notes: _____

_____

Dentist Initials: _____

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ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

Financial Responsibility (All)
All professional services rendered are charged to the patient and **are due at the time of services**, 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 check(s) directly to **Gardner Springs Dentistry** for dental services rendered to myself and/or my dependent(s) regardless of my insurance benefits, if any. 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(s) of a dental claim is not guaranteed by any insurance and is 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/my dependent(s) dental treatment, to process my insurance claim acquired in the course of my/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 in 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.

_____ _____ (Print) Responsible Party Name / Date

_____ _____ (Signature) Responsible Party Name/ Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have been given the opportunity to review/have reviewed a copy of this office's Notice of Privacy Practices (HIPAA) and have had the opportunity to ask questions regarding HIPAA.

Patient's Printed Name: _____

Patient's/Guardian Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained because.

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____