

Gardner  Springs
DENTISTRY

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:

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

Do you like the appearance of your smile? YES NO

If not, what would you like to change about your smile? _____

Do you feel nervous at the Dental Office? YES NO

Have you ever had an unpleasant dental experience? YES NO

Is there anything you would like us to know to make your dental experience more comfortable?

Are you interested in learning more about the following?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Invisalign | <input type="checkbox"/> Dental implants | <input type="checkbox"/> Cosmetic Dentistry | <input type="checkbox"/> Teeth Whitening |
| <input type="checkbox"/> Sedation Dentistry | <input type="checkbox"/> Headache relief | <input type="checkbox"/> Missing tooth replacement | <input type="checkbox"/> TMJ Appliance |
| <input type="checkbox"/> 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:

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

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

Tobacco/Nicotine? - How often: _____ 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | <input type="checkbox"/> Food: _____ |
| <input type="checkbox"/> Acetaminophen(Tylenol) | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> NSAID's(Ibuprofen, Aspirin) | <input type="checkbox"/> Metals | <input type="checkbox"/> 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

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed, and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information within the timeframe required by law. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit (restrict) what we use or share.

- You can ask us not to use or share certain health information by sending us a written request that includes (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

- You can ask for a list (accounting) of the times we've shared your health information, who we shared it with, and why.
- We will include all the disclosures except for those related to treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us using the information at the top of this page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:
Treat you.

We can use your health information to treat you and share it with other professionals who are treating you making your health information subject to redisclosure.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization.

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services.

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more info see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues.

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and/or preventing or reducing a serious threat to anyone's health or safety.

Do research.

We can use or share your information for health research.

Comply with the law.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests.

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director.

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions.

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Substance Use Disorder (SUD) Treatment Information. If we create, receive, or maintain any information about you regarding a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

Our Responsibilities

- We are required by federal and state law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your Protected Health Information (PHI) electronically or otherwise other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticemp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective date: 2/16/2026

**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: _____

OTHER: _____

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