GILBERT CENTER
GD
DENTISTRY

PATIENT INFORMATION

Date_____

Patient Name_____**Preferred**_____
Last First M.I.

Social Security #_____

Male
Female

Referred By_____

Birth Date_____ **Age**_____ Married Single Divorced Widowed Child

Address_____
Street Apartment #

_____
City State Zip Code

Home Phone_____**Cell Phone**_____

Work Phone_____**Ext**_____

Email_____

RESPONSIBLE PARTY:
Name_____**Relationship to Patient**_____
Address_____
Home Phone_____ **Cell Phone**_____
Work Phone_____**Ext**_____

INSURANCE INFORMATION:
Primary
Insurance Plan Name_____**Employer**_____
Subscriber's Name_____**DOB**_____
Social Security #_____
Patient's relationship to Subscriber Self Spouse Child Other

Secondary
Insurance Plan Name_____**Employer**_____
Subscriber's Name_____**DOB**_____
Social Security #_____
Patient's relationship to Subscriber Self Spouse Child Other

HEALTH INFORMATION

Have you ever had any of the following?

- □ AIDS/HIV
- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial Joints
- □ Asthma
- □ Bleeding abnormally
- □ Blood Disease
- □ Cancer
- □ Chemotherapy
- □ Diabetes
- □ Drug Abuse
- □ Epilepsy
- □ Fainting or dizziness
- □ Glaucoma
- □ Headaches
- □ Heart Murmur
- □ Heart Problems
- □ Hepatitis Type _____
- □ High Blood Pressure
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Low Blood Pressure
- □ Low Blood Pressure
- □ Nervous Problems
- □ Osteoporosis

Please check those that apply:

- □ Pacemaker
- □ Psychiatric Care
- □ Radiation Treatment
- □ Respiratory Disease
- □ Rheumatic Fever
- □ Stroke
- □ Thyroid Disease
- □ Tobacco Use
- □ Tuberculosis
- □ Tumors
- □ Ulcer

Women: Are you pregnant?_____ Due date_____ Are you nursing?_____

Are you now under the care of a physician_____ If yes, please explain_____

Name of Physician_____Phone_____

Have you ever been told to pre-medicate with antibiotics before your dental appointment?_____

MEDICATIONS

List any medications you are currently taking

_____
_____
_____
_____
_____

Are you now or have you taken Bisphosphanates? (Fosamax, Moniva, Actonel)

□ **Yes**
□ **No**

ALLERGIES

- □ Aspirin
- □ Anesthetic
- □ Codeine
- □ Iodine
- □ Latex
- □ Penicillin
- □ Sulfa
- □ Other_____

PHARMACY NAME_____
PHONE_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date**_____

Signature of patient, parent or guardian

Gilbert Center Family & Cosmetic Dentistry

Patient's Name_____

1. Do you fear coming to the dental office? □ Yes □ No

2. Do you have any present dental complaints? □ Yes □ No

3. Are your teeth sensitive to: Heat? Cold? Sweets? Biting Pressure?

4. Does food catch between your teeth? □ Yes □ No

5. Do your gums bleed when brushing? □ Yes □ No

6. Have you noticed swelling around any teeth? □ Yes □ No

7. Do you have an unpleasant taste or order in your mouth? □ Yes □ No

8. Do you ever avoid any part of your mouth when brushing? □ Yes □ No

9. Do you smoke? □ Yes □ No

10. Would you be interested in getting screened for Oral Cancer? □ Yes □ No

11. Do you like the appearance of your teeth; your smile? □ Yes □ No

12. Are your teeth all in alignment □ Yes □ No

13. Do you have spaces that you don't like? □ Yes □ No

14. Do you like the color of your teeth? □ Yes □ No

15. Do you like the shape of your teeth? □ Yes □ No

16 Are your teeth: chipped? protruding? hidden?

17. Are your teeth wearing on the biting surfaces? □ Yes □ No

18. Are there old fillings or dental work that you don't like looking at? □ Yes □ No

What would you like to change the most in the appearance of your teeth?

_____

_____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE!

CONSENT FOR SERVICES AND OFFICE POLICIES:

The undersigned hereby authorized Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with patient and further authorize and consent the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agent embodies a certain risk. For minor consent, I do hereby request and authorize the dental staff to perform necessary dental services for my child and perform administrations of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

FINANCIAL POLICY:

- I acknowledge that full payment is due at the time of treatment for all services rendered. I understand that full responsibility for payment of all dental services in this office for myself and my dependents is mine. I accept full financial responsibility for all charges whether or not paid by my dental insurance company. Patients who carry dental insurance understand that all dental services furnished are ultimately the responsibility of the patient and that he or she is personally responsible for payment of all dental services. As a courtesy, this office will help prepare the patients primary insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We will also submit your secondary insurance claim. Not all services are a covered benefit in all insurance contracts. Some insurance companies arbitrarily select certain services they will not cover. We make every attempt to know plan provisions and benefits for major employers, however we cannot possibly know what every insurance carrier will or will not pay.
- If insurance fails to provide payment, I am responsible for the unpaid balance. Any unpaid balances on services rendered that are not paid in full after 60 days of date of service may be assessed a 3% finance charge per month overdue. Failure to comply with any financial arrangements may also be assessed a 3% finance charge.
- Furthermore, in the case of payment default for services previously rendered, I agree to pay all collection and or legal fees incurred in an attempt to collect on this amount or any further outstanding balances.
- A $25 charge will be applied to your account on all returned checks.
- If necessary, I authorize this office to make inquiries with Credit Reporting Agencies regarding me, or if a married person, my marital community including my spouse. I hereby waive any confidentiality associated therewith.

WARRANTY ON CROWN OR BRIDGE:

For a period of two (2) years from the date of service, we will remake the crown or bridge due to breakage or misfit at no cost to the patient.
All warranties will be null and void if the patient does not maintain his/her recommended three, four or six month hygiene or periodontal maintenance appointments.

CANCELLATIONS:

We do charge $25.00 or 10% of the scheduled treatment, whichever is greater, for those appointments that are canceled or broken with less than 24 hour notice. We do understand emergencies do arise and we will try and work with you in these situations, but we would appreciate it if you would call our office as soon as possible if you need to cancel or reschedule an appointment.

I have read the above conditions of treatment and payment and agree to their content.

_____Date:_____Relationship to Patient:_____
Signature of patient, parent or guardian

_____Date:_____Relationship to Patient:_____
Signature of responsible party

GILBERT CENTER
Family and Cosmetic Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____, have read a copy of this office's Notice of Privacy Practices.

_____
Please print name

_____ _____
Signature Date

For Office Use Only

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