

Gilbert Cosmetic & Family Dentistry

*We are pleased to welcome to our practice!
Please take a few minutes to fill out the following forms
completely.*

Patient Information

Name _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Work: _____ Cell: _____

Male: _____ Female: _____ DOB: _____

Social Security # (REQUIRED) _____

Single: _____ Married: _____ Widowed: _____

Patient Employed by: _____ Occupation: _____

Business Address: _____

Notify in case of emergency: _____ Relationship: _____

Emergency contact phone #: _____

Who May We Thank for referring you: _____

Email Address: _____

Primary Insurance

Person responsible for Account _____

Relation to patient _____ DOB: _____ Soc. Sec #: _____

Address (if different than patient) _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Phone#: _____

Group#: _____ Subscriber ID: _____

Name of other dependents under this plan _____

Please Complete All Pages

Medical History

Physicians Name: _____ Phone # _____

Date of Last Visit: _____ Have you had and serious illness or operations Y () N () If yes, describe _____

List of medications you are currently taking _____

Are you currently under physician care? Y () N () If yes, describe _____

Women: Are you pregnant? Y () N () Nursing? Y () N () Taking birth control Y () N ()

Check () if you have any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> Fainting | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Arthritis,
Rheumatism | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatics/ Scarlet
Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemophilia/
abnormal bleeding | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Swelling feet/ ankles |
| <input type="checkbox"/> Chemical/ Alcohol
Dependency | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Mitral Valve
Prolapse | <input type="checkbox"/> Tonsillitis
Tuberculosis |
| <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Nervous Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker/ heart
surgery | |
| <input type="checkbox"/> Epilepsy | | |

Please check any Allergies:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Latex Rubber | <input type="checkbox"/> Material Allergies
(latex, metal, wool,
chemical) | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Penicillin /Antibiotics | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Local Anesthetics (e.g.
Novocain) | <input type="checkbox"/> Iodine | <input type="checkbox"/> Sedatives |
| | | <input type="checkbox"/> Others _____ |

Dental History

Date of last dental appointment: _____ Date of Last X-Rays _____

Date of last Cleaning: _____

Is there any history of periodontal therapy? _____

Are you happy with your smile? _____

Is there anything about your teeth that you would like to change?

Are you interested in a brighter, whiter smile?

If you had a magic wand what you change about your teeth?

Check () if you have a problem with any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Food collecting between teeth | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Loose teeth/ broken fillings | <input type="checkbox"/> Sensitivity to biting |
| <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores/ growth in mouth |

Do you experience any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Clenching/ Grinding | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chewing Difficulties |
| <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Postural problems |
| <input type="checkbox"/> Clicking/ popping jaw | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Limited mouth opening | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Ear congestion | <input type="checkbox"/> ringing in ear |
| <input type="checkbox"/> Dizziness | |

Are there any other dental concerns that you are having that you would like us to know about?

Authorization

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 diagnosis/ records of any treatment/ examination rendered to me my child during the period of such dental care to third party payers/ health practitioners. I authorize and request my insurance to pay directly to the dentist/ 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 dependants. I am aware of the missed that the actual bill for appointment/cancellation fee if I fail to speak to the office staff and give them at least two business days notice to cancel or reschedule any appointment.

Signature: _____ Date: _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Doctor's Signature: _____ Date: _____

Doctor's Comments: _____

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Missed Appointment Policy

Missed appointments and appointments cancelled without 2 business days notice are subject to a cancellation fee of \$50 per half hour of the scheduled appointment time. Any appointments scheduled for 90 or more minutes are subject to a minimum cancellation fee equal to 50% of the procedure(s) fee, some appointments may be subject to 100% of the procedure fee.

Signature: _____ Date: _____
Print Name: _____

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NOTICE OF PRIVACY PRACTICES

Purpose: This Notice of Privacy Practices presents the information that the HIPAA Privacy Rules.

We must provide this Notice to each patient no later than the date of our first service delivery to the patient, after April 14, 2003. We must also have the Notice available at the office for patients to request to take with them. Whenever we revise the Notice, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised notice in our office as discussed above.

We must make a good faith effort to obtain a written acknowledgement of receipt of this Notice from each individual with whom we have a direct treatment relationship and to whom we provide this Notice, except in emergency situations. If we do not obtain the acknowledgement, we must document our efforts and the reason we did not obtain the acknowledgement. The last page of the Notice is a written acknowledgement that each patient should sign. We should keep the acknowledgement in the patient's medical record.

I, _____, acknowledge that I have received a Notice of Privacy Practice from the above named practice.

Signature: _____ Date: _____
Our Privacy Practice in its entirety is available upon request. Thank you.