PATIENT INFORMATION

Date:__________________

Patient Name:____Preferred___________________
Last First MI
Male Female

Birthdate________________________Age_____ Married Single Divorced Widowed Child

Address:____
Street Apartment #
____
City State Zip Code

Home Phone:______________________________Cell Phone:_________________________________

Work Phone:______________________________Ext:___________

Email:____

WHEN CONFIRMING AND/OR REMINDING YOU OF YOUR APPOINTMENT:
WOULD YOU PREFER: TEXT MESSAGING _____ EMAIL _______ OR BOTH ________

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 relation ship 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? Please check those that apply:

- ☐ 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
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Osteoporosis
- ☐ 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:
____
____
____
____

PHARMACY NAME____________________
PHONE_______________________________

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Anesthetic
- ☐ Penicillin
- ☐ Sulfa

____
____
____
____

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

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.

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 regular three, four or six month hygiene or periodontal maintenance appointments.

CANCELLATIONS:
We do charge $25.00 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)

____

____

____

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 odor 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 you don't like looking at? YES NO
19. What would you like to change the most in the appearance of your teeth?
____
____
20. If we could change your smile without the use of a drill or shots …would you be interested?
YES NO

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONAIRE.

GILBERT CENTER
Family and Cosmetic Dentistry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 12/01/04, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federl officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.20 for each page, $1.00 per x-ray, and $18.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before December 1, 2004. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.