

# Gilbert Center

Family and Cosmetic Dentistry

Date \_\_\_\_\_

Purpose of visit \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_ Phone \_\_\_\_\_

Dr.  Mr.  Mrs.  Miss  Ms. \_\_\_\_\_  
Last First M.I.

Preferred Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ E-Mail \_\_\_\_\_

What is the best way to contact you during the day? \_\_\_\_\_ At night? \_\_\_\_\_

May we text and/or email you appointment reminders? \_\_\_\_\_

Check appropriate box  Minor  Single  Married  Divorced  Widowed  Separated

If college student, F.T./P.T., name of school \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Patient or parent's employer \_\_\_\_\_ No. of years \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_  
Street City State Zip Code

Name of Spouse \_\_\_\_\_ Birth Date \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Cell Phone \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Landlord \_\_\_\_\_ Phone \_\_\_\_\_

Nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Whom may we contact in case of an emergency \_\_\_\_\_ Phone \_\_\_\_\_

**Responsible Party**

Name of person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birth Date \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this person currently a patient in our office?    Yes    No

**Insurance Information**

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Date employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Tel. # \_\_\_\_\_ Grp.# \_\_\_\_\_ Policy/I.D.# \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max annual benefit \_\_\_\_\_

Do you have any additional insurance?    Yes    No    If yes, complete the following:

Name of Insured \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Date employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Tel. # \_\_\_\_\_ Grp.# \_\_\_\_\_ Policy/I.D.# \_\_\_\_\_

Ins. Co. address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max annual benefit \_\_\_\_\_

Payment is due on the day of treatment. Responsible party for payment \_\_\_\_\_

I have read all the information on these sheets and have completed the answers. I certify that this information is **true** and **correct** to the best of my knowledge. **I will notify you of any changes in my health status or the above information.**

Signature of Patient or Parent if patient is a minor \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY:** Date of last examination \_\_\_\_\_

Name of Physician \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Do you have a current medical problem?  Yes  No Explain \_\_\_\_\_

Do you smoke or use tobacco?  Yes  No How much? \_\_\_\_\_

**HAVE YOU EVER HAD ANY OF THE FOLLOWING? Please check those that apply:**

- |  |                             |   |   |
|--|-----------------------------|---|---|
| <input type="checkbox"/> AIDS/HIV                  | <input type="checkbox"/> He | <input type="checkbox"/> Heart Murmur                   | <input type="checkbox"/> Pain, Pressure, Tightness in Chest |
| <input type="checkbox"/> Alcohol or Drug Abuse     |                             | <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Psychotherapy                      |
| <input type="checkbox"/> Anemia/Leukemia           |                             | <input type="checkbox"/> Jaundice, Hepatitis Type _____ | <input type="checkbox"/> Respiratory Disease                |
| <input type="checkbox"/> Arthritis, Sore Joints    |                             | <input type="checkbox"/> Jaw Pain                       | <input type="checkbox"/> Rheumatic Fever                    |
| <input type="checkbox"/> Artificial Joints         |                             | <input type="checkbox"/> Kidney Disease                 | <input type="checkbox"/> Shortness of Breath                |
| <input type="checkbox"/> Asthma/Emphysema          |                             | <input type="checkbox"/> Liver Disease                  | <input type="checkbox"/> Stroke                             |
| <input type="checkbox"/> Blood Disease             |                             | <input type="checkbox"/> Low Blood Pressure             | <input type="checkbox"/> Swelling Ankles/Feet               |
| <input type="checkbox"/> Convulsions               |                             | <input type="checkbox"/> Mitral Valve Prolapse          | <input type="checkbox"/> Thyroid Disease                    |
| <input type="checkbox"/> Diabetes                  |                             | <input type="checkbox"/> Nervous Breakdown              | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Epilepsy, Fainting Spells |                             | <input type="checkbox"/> Osteoporosis                   | <input type="checkbox"/> Ulcer                              |
| <input type="checkbox"/> Glaucoma                  |                             | <input type="checkbox"/> Pacemaker                      | <input type="checkbox"/> X-ray, Chemo/Radiation Therapy     |
| <input type="checkbox"/> Heart Attack              |                             |   | <input type="checkbox"/> Other                              |

**ARE YOU NOW:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Using anticoagulants | <input type="checkbox"/> Using anti-depressants | <input type="checkbox"/> Taking blood pressure meds |
| <input type="checkbox"/> On a prescribed diet | <input type="checkbox"/> Using thyroid pills    |   |

Women: Are you pregnant? \_\_\_\_\_ Due date \_\_\_\_\_ Are you nursing? \_\_\_\_\_

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

**ARE YOU NOW TAKING OR USING MEDICATION FOR:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Diabetes (pills or shots) | <input type="checkbox"/> Nerves (tranquilizers)   | <input type="checkbox"/> Arthritis or Rheumatism |
| <input type="checkbox"/> Stomach (ulcer, other)    | <input type="checkbox"/> Blood (liver/iron pills) | <input type="checkbox"/> Allergies               |
| <input type="checkbox"/> Heart or Blood Pressure   |   |  |

**MEDICATIONS:**

List any medications you are currently taking:

---

---

---

**HAVE YOU EVER BEEN SICK FROM, SHOWN AN ALLERGY TO OR TOLD NOT TO TAKE:**

- |   |                                      |                                      |
|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Antibiotics                            | <input type="checkbox"/> Codeine     | <input type="checkbox"/> Aspirin     |
| <input type="checkbox"/> Metals                                 | <input type="checkbox"/> Latex       | <input type="checkbox"/> Penicillin  |
| <input type="checkbox"/> Tetracycline                           | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Novocaine (or other dental anesthetic) |                                      |                                      |



Are you now or have you taken Bisphosphonates? (Fosamax, Boniva, Actonel)  Yes  No

Have you ever taken PhenFen?  Yes  No

Have you ever had a tumor or cancer?  
Where? \_\_\_\_\_  Yes  No

Have you ever had a major operation?  
Where? \_\_\_\_\_  Yes  No

Have you ever been in a serious accident?  
Describe \_\_\_\_\_  Yes  No

Following injuries, have you ever had bleeding problems?  Yes  No

Do injuries and cuts take longer to heal now than previously?  Yes  No

Have you recently lost weight unintentionally?  Yes  No

Is there a history of diabetes in your family?  Yes  No

Pharmacy Name \_\_\_\_\_

Phone \_\_\_\_\_

**DENTAL HISTORY:** Date of last examination \_\_\_\_\_ Former Dentist \_\_\_\_\_

Have you come to this office for relief of pain?  Yes  No

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

Do your gums bleed when brushing your teeth?  Yes  No

Do you floss? If so, how often \_\_\_\_\_  Yes  No

Does food catch between your teeth?  Yes  No

Have you noticed swelling around any teeth?  Yes  No

Do you have an unpleasant taste or odor in your mouth?  Yes  No

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

Have you ever been diagnosed with periodontitis?  Yes  No

Do you clench or grind your teeth during the day?  Yes  No

Do you clench or grind your teeth during the night?  Yes  No

Do you have chronic headaches or neck and shoulder pain?  Yes  No

Do you ever wake up with an awareness of your teeth or jaw,  
as if you've had them clenched in your sleep?  Yes  No

---

**Do you now or have you ever had pain in your jaw joint or the sides of your face (in and around your ears)?**  **Yes**  **No**

**Do you have clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?**  **Yes**  **No**

**Do you like the appearance of your teeth; your smile?**  **Yes**  **No**

**Are your teeth in alignment?**  **Yes**  **No**

**Do you have spaces that you don't like?**  **Yes**  **No**

**Do you like the color of your teeth?**  **Yes**  **No**

**Do you like the shape of your teeth?**  **Yes**  **No**

**Are your teeth:** **chipped?** **protruding?** **hidden?**

**Are there any old fillings or dental work you don't like looking at?**  **Yes**  **No**

**Do you feel nervous about having dental treatment?**  **Yes**  **No**

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

---

---

**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.**

\_\_\_\_\_  
**Signature of patient, parent or guardian** **Date:** \_\_\_\_\_

**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.

\_\_\_\_\_  
Signature of patient, parent or guardian      Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of responsible party      Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**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)
- 
-