WELCOME TO GLADURA DENTAL

Thank you for selecting our practice for your dental care! We would like to thank the person who referred you to us. Please write their name below. If you weren't referred to us by a patient, we would still like to know how you heard about us (Google/Bing/Yahoo search, Facebook/Twitter, Direct Mail, Physician, Outside Sign, Insurance website, or Other.)

_____

Referred by

Patient Information

Date _____ Soc. Security # _____ DOB _____

Name _____ Preferred Name_____

Last Name First Name Initial

Address _____ Email _____

City _____ State/Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Primary Phone: O Cell O Home O Work **Gender**: O Male O Female

Marital Status: O Married O Single O Divorced O Separated O Widowed

Student: O Y O N If under 18, Parental Guardian's Name _____

Name of person responsible for account if different from patient _____

Address _____

City, State, Zip _____

Relationship _____ Best phone number _____

Address _____

Emergency contact _____

Name Best Phone Number Relationship

Dental Insurance

_____ _____ _____

Primary Dental Insurance Company Subscriber's Name Subscriber's Soc Sec.

#/ID# _____ _____

Subscriber's Date of Birth Employer Name Group/Plan Number

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Dental History

Do you require antibiotics before dental treatment? O Y O N

Are you currently in pain? O Y O N

Have you ever had gum treatment? O Y O N

Are you aware of popping, clicking, or snapping noises when you chew or open/close your mouth? O Y O N

Are you aware of grinding or clenching your teeth? O Y O N

Is there anything about your mouth that concerns you now?_____

_____

Is there anything about your smile you would like to change? _____

_____

How often do you brush?_____ Floss?_____

When was your last dental office visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Does food lodge between your teeth? _____

Do you feel you have unpleasant breath or taste in your mouth? _____

Are you aware of grinding or clenching your teeth? _____

Do you have headaches? _____

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Guardian or Personal Representative Date

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Medical History Update

Last Name:_____ First Name:_____ Birthdate:_____

List any medications that you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

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

Do you have any of the following medical conditions?

- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pregnancy
- ☐ Psychiatric Treatment
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Ulcers
- ☐ Rheumatic Fever
- ☐ Other: _____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason For today's visit? _____ Are you in pain? _____

New Patients:

Do you have a panoramic x-ray or full mouth x-ray that is less than 5 years old? _____

Do you have bitewing x-rays that are less than 1 year old? _____

Name of former dental office_____ City/State _____

Date of last cleaning _____

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PATIENT CONSENT

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.

I understand that I may withdraw or revoke my authorization at any time. I may revoke this authorization by notifying my practice in writing.

I understand that by signing this Consent form, I am giving my consent to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations.

The undersigned hereby authorizes the dentist to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

Patient Signature

Date

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please *print* name of Patient Please *sign* Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:**

☐ Cell Phone Confirmation
☐ Text Message to my Cell Phone
☐ Home Phone Confirmation
☐ Email Confirmation
☐ Work Phone Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Text Message to my Cell Phone
☐ Home Phone Confirmation
☐ Email Confirmation
☐ Work Phone Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

FINANCIAL POLICY

PAYMENT OPTIONS

Cash, Check, Money Order, Visa, MasterCard, American Express, Care Credit. Payment is due at the time service rendered unless prior financial arrangements have been made.

INSURANCE

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately.

EMERGENCY/NEW PATIENTS

Patients must pay at the time of service until they are established as an existing, participating patient and then payment policies will apply.

COURTESIES

-Patients without insurance - Payment in full at the time of appointment by check or cash (this does not include Care Credit or major debit/credit cards) will receive a 10% courtesy on treatment.

-Senior Citizens (age 65 plus) without insurance – A 15% courtesy on treatment will be applied to those in good financial standing with the office.

-Care Credit is available for those who qualify. This is an external financing source which can finance treatment from $200 - $25,000.

MINORS WITH SEPARATED PARENTS

When two parents are each responsible for one half of the cost of the child's dental care, the parent who brings the child is responsible for paying the co-payment or full fee. We will provide a receipt to assist the parent to collect payment from the other parent.

NSF/RETURNED CHECKS

There will be a fee of $35 for processing a returned or NSF check.

COLLECTIONS

If your account must be turned over to collections, a 25% collection fee will be added to your account. However, rates are subject to vary.

NO SHOW/RESCHEDULE POLICY

The practice reserves the right to charge a $25 fee for no show appointments or appointments canceled without a 24-hour notice. First time offenders will be billed this fee and then it will be reversed from their account.
-- I confirm that I have read, understand, and agree to the above terms and conditions. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

Signature_____ Date_____

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