Gulf Islands Dentistry

Your information will be totally confidential within this office

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Marital Status M S W D

Social Security #: _____ Birth Date:_____ Age:____

Phone (Home): _____ (Work): _____ Ext: _____Cell Phone # _____

E-Mail Address_____

Address: _____
Street Apartment #

_____
City State Zip Code

Who may we thank for referring you?

Occupation_____Employer_____
Employer Address _____ How long? _____

Spouse's Name: _____Occupation: _____
Birth Date: _____ Social Security # _____-_____-_____
Employer (name & address) _____ How long? _____

Nearest Relative or Friend (not living with patient) _____ Relationship _____
Address: _____ Phone#: (___)_____-_____

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½% per month 18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. There will be a $30.00 return check fee for all checks returned for non-payment.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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 or guarantor of payment/responsible party

Health Information

Have you ever had any of the following? Please check those that apply:

- ❒ AIDS
- ❒ Allergies _____ _____
- ❒ Anemia
- ❒ Arthritis
- ❒ Artificial Joints
- ❒ Asthma
- □ Alcohol/Drug Dependent
- ❒ Cancer
- ❒ Diabetes
- ❒ Dizziness
- ❒ Epilepsy
- ❒ Excessive Bleeding
- ❒ Fainting
- ❒ Glaucoma
- ❒ Head Injuries
- ❒ Heart Disease
- ❒ Heart Murmur/MVP
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ Jaundice
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Mental Disorders
- ❒ Nervous Disorders
- ❒ Pacemaker
- ❒ Currently Pregnant Due Date: _____
- ❒ Radiation Treatment
- ❒ Respiratory Problems
- ❒ Rheumatic Fever
- ❒ Sinus Problem
- ❒ Stomach Problems
- ❒ Stroke
- ❒ Tuberculosis
- ❒ Tumors
- ❒ Sexually Transmitted Disease
- ❒ Codeine Allergy
- ❒ Penicillin Allergy

Other Drug Allergies:
_____
_____

Physician (name & address) _____

- Have you ever had any complications following dental treatment? ❒Yes ❒ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ❒Yes ❒No
  If yes, please explain: _____
- Are you now under the care of a physician? ❒Yes ❒No
  If yes, please explain: _____
- Are you currently taking any medicines or drugs including Birth Control Pills? ❒Yes ❒No
  If yes, please explain: _____
- Are you allergic to any metals? ❒Yes ❒No If yes, explain: _____
- Do you have any health problems that need further clarification? ❒Yes ❒No
  If yes, please explain: _____

Former Dentist (name & address) _____

Dental Information

- Last Dental Visit (approximate date or approximate number of years since your last visit).____
- Do you have any current dental concerns? (Circle as many as apply) sensitivity, pain, swelling, broken teeth, lost fillings/crowns, bleeding gums, bad breath, recent spacing of teeth or any other concerns that you can list. _____
- Have you ever had a dentist tell you that you had gum disease (pyorrhea, periodontal disease)?____
- Do you have missing teeth that you would like to discuss replacing?_____
- Would you like to discuss changing anything about your smile?_____ If yes, what? (tooth color, tooth alignment or position, filling spaces, or something other than the listed._____
- Have you had difficult past dental visits?_____ Would you like to discuss the possibility of anxiety reduction or sedation if you require involved dental treatment?_____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ❒Yes ❒No
Last First MI

Insurance Plan Name and Address: _____

Insured's Birth Date: _____ ID# _____ Group# _____

Insured's Employer Name: _____ Address: _____
Street/City/State /Zip Code

Patient's relationship to insured: ❒ Self ❒ Spouse ❒ Child ❒ Other _____

Russell Parker, DMD
Jessica Taylor, DMD
Acknowledgement of Receipt of Notice Of Privacy Practices

You May Refuse to Sign this Acknowledgment

I, _____, have received 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 abknowledgement
- ○ An emergency situation prevented us form obtaining acknowledgement
- ○ Other (Please Specify)