GATEWAY DENTAL CARE

"Your Smile is our Goal"

51611 Ten Mile Rd., South Lyon (248) 278-0031 • 25660 Pontiac Trail, South Lyon (248) 446-2700

Chart #:____________
FOR OFFICE UUSE ONLY

Patient Information

Patient Name: ____ Date:______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________________

Social Security #: ____________ Birthdate: ____________ Driver's License #____________ State______

Phone (Home): (____)____________ (Cell) (_____)____________ (Work): (_____)____________ Ext:______

Home Street Address: ______________________________________
Street Apartment #

City, State Zip ______________ ________ ________ Email____________________
City State Zip Code

Health Information

Date of Last Dental Visit: ____________ Reason for this visit:______________________________

Have you ever had any of the following? Please read this carefully and circle Y for Yes and N for No:

AIDS/HIV	Y	N	Hepatitis	Y	N	Stroke	Y	N	Latex Allergy	Y N
Anemia	Y	N	High Blood Pressure	Y	N	Taking Blood Thinner	Y	N	Penicillin Allergy	Y N
Artificial Joints	Y	N	Jaundice	Y	N	Thyroid Disorder	Y	N	Other Allergies____________	
Asthma	Y	N	Kidney Disease	Y	N	Tuberculosis	Y	N	OTHER:	
Auto Immune Disorder	Y	N	Liver Disease	Y	N	Tumors/Cysts	Y	N	☐ ____________	
Cancer__________	Y	N	Mental Disorders	Y	N	Ulcers	Y	N	☐ ____________	
Diabetes	Y	N	Pacemaker	Y	N	Venereal Disease	Y	N		
Epilepsy	Y	N	Pregnant	Y	N	Other	Y	N		
Excessive Bleeding	Y	N	Due Date: __________			Explain:__________				
Fainting	Y	N	Respiratory Problems	Y	N	**ALLERGIES:**				
Head Injuries	Y	N	Rheumatic Fever	Y	N	Anesthetic Allergy	Y	N		
Head-Neck Radiation	Y	N	Sinus Problems	Y	N	______________				
Heart Disease	Y	N	Snoring	Y	N	Aspirin Allergy	Y	N		
Heart Murmur, Functional	Y	N	Stomach Problems	Y	N	Codeine Allergy	Y	N		

Official Use Only
☐ PreMedicate ☐ No Epinephrine
Dr/RDH______________________
Date________________________

- 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: ____
  Name of Physician: ______________________________ Phone:______________
- Whom may we contact in the event of a medical emergency? Name__________________________
  Relationship to patient______________ Day Phone______________ Eve Phone______________
- What medications, vitamins, or herbal remedies are you taking at this time? ____________________

____

- Do your gums bleed when you floss or brush? ☐ Yes ☐ No
- Do you smoke? ☐ Yes ☐ No If yes, how much do you smoke daily? ____________________
- Have you ever used recreational drugs? ☐ Yes ☐ No If yes, explain____________________
- Do you have frequent headaches? ☐ Yes ☐ No Do you clench or grind your teeth? ☐ Yes ☐ No
- Does your jaw ever get "stuck," locked," or "go out"? ☐ Yes ☐ No
- What changes would you like to make to the appearance of your teeth? ____________________

____

Have you ever had an unfavorable reaction to Nitrous Oxide? ☐ Yes ☐ No If yes, explain____________________

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.

X Signature of patient, parent or guardian______________________________ Date:__________

PERMISSION TO DENTISTS/HYGIENISTS -- I give my consent to use local anesthetic or relaxants for completing necessary dental treatment.

X Signature of patient, parent or guardian______________________________ Date:__________

Cosmetic Information

Is there anything about your smile that you do not like? ____

Are you interested in knowing the options available for a more beautiful smile? ____________________________

Do you like the appearance of your teeth? ____

Are all of your teeth in alignment (straight)? ____

Do you have any missing teeth? ______________ Are any chipped? __________________________________

Is your bite comfortable when chewing, biting? ____

Do you have frequent headaches? ____

Do you have any old fillings or dental treatment that you are unhappy with? ____________________________

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

____

____

Is there anything else that you would like us to know? ____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Internet Search Please specify what internet source you used to locate us. ______________________________

☐ Yellow Pages Please specify____________ ☐ School Sponsorship ☐ Direct Mail Postcard ☐ Other________________

Name of person or office referring you to our practice:____

Patient Employment

Employer Name: ______________________________ Occupation: ______________________________

Address: ____

Street City State Zip Code

Employer Phone: ______________________________

Spouse or Guardian Information

The following is for: ☐ the patient's spouse ☐ parent ☐ guardian

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ______________________________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): ________________ (Work): ________________ Ext:______ Best time to call: ________________

Home Street Address: ____

City, State, Zip: ____

Employer Name: ______________________________ Occupation: ______________________________

Street, City, State, Zip ____

Insurance Information

Primary:

Name of Insured: ______________________________Relationship to Patient:______________________________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): ________________ (Work): ________________ Ext:______ Best time to call: ________________

Home Street Address: ____

City, State, Zip: ____

Employer Name: ______________________________

Insurance Company ______________________________ Group #________________ Union or Local #________________

Street, City, State, Zip ____

How much is your deductible:____________ How much have your used?____________________Max Annual Benefit? $________

Insurance Information

Secondary:

Name of Insured: ______________________ Relationship to Patient: ______________________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ Ext:______ Best time to call: ____________

Home Street Address: ______________________

City, State, Zip: ______________________

Employer Name: ______________________

Insurance Company ______________________ Group #__________ Union or Local #__________

Street, City, State, Zip ______________________

How much is your deductible:__________ How much have your used?__________ Max Annual Benefit? $________

Consent for Services

As a condition of your treatment by this office, all emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or by credit card at the time services are performed. The practice depends upon reimbursement from the patients for the costs incurred in their care. As a condition of your treatment by this office, services are to be paid when rendered, or definite financial arrangements must be made and approved by Gateway Dental Care prior to commencement of treatment.

Patients who carry dental insurance understand that all dental services furnished are the responsibility of the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. Any estimate of coverage is not a guarantee, as eligibility, policy provisions and possible charges from other offices affect payment. In summary, your insurance company may not pay the full estimated portion. *THE PATIENT IS RESPONSIBLE FOR ALL TREATMENT CHARGES NOT PAID BY YOUR INSURANCE.*

In consideration for the professional services rendered to me, by the Doctor or Hygienist, I agree to pay therefore the reasonable value of said services to Gateway Dental Care, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed.

REGARDING MISSED OR CANCELED APPOINTMENTS: Once I make an appointment, the time will be reserved for me. If I miss or cancel a dental appointment without 48 hours advance notice, *I agree to pay $25 for each one-half hour of appointment time reserved*. This policy is needed to prevent delays of my treatment as well as other patients. I realize that the delay of a missed or cancelled appointment may jeopardize my dental health.

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.

X Signature of patient, parent or guardian______________________ Date: __________ Relationship to Patient: __________

X Signature of guarantor of payment/responsible party______________________ Date: __________ Relationship to Patient: __________

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: ____________________ Patient Name: ____

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.

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

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❏ It was emergency treatment
❏ I could not communicate with the patient
❏ The patient refused to sign
❏ The patient was unable to sign because
❏ Other (please describe)____

Signature of Privacy Officer ______________________________________