Gustafson
DENTAL

REGISTRATION AND HEALTH RECORD

Today's Date _____

Name _____ Age_____ Sex_____ Marital Status _____
First *Middle* *Last*

Residence Address _____
Street *City* *State* *Zip Code*

Birth Date _____ Home Phone _____

Social Security # _____ Cell Phone _____

Emergency Contact _____ Contact Phone _____

Employed By _____ Their Phone _____

Employer's Address _____ Email _____

Your Driver's License No. _____ Occupation _____

Person Financially Responsible _____ Their Phone _____

Responsible Party's Home Address _____ Their Work Number _____

Spouse Name _____ Birth date _____ Driver's License # _____

Employed By _____ Work Phone _____

Spouse Social Security # _____ Names of family members we have seen _____

Whom may we thank for referring you to our office? ❑ Newspaper ❑ Yellow Pages ❑ Web site Name _____

I verify the above and give my consent for treatment and I also understand that I am financially responsible for all dental services rendered. I agree that payment is to be made on the same day services are rendered.

Signature _____

How will your account be paid? ❑ Cash ❑ Check ❑ Visa ❑ Mastercard ❑ Discover ❑ American Express ❑ Including Insurance

As a courtesy, we will verify your dental insurance coverage, you must pay the difference between our fees and your insurance benefits for all services rendered including orthodontics.

Signature _____

DENTAL HISTORY

Do you have any present dental complaints? ❑ Yes ❑ No If so, what? _____

When was your last cleaning? _____

Date of last dental treatment _____

Are your gums tender? ❑ Yes ❑ No

Do they bleed when you brush? ❑ Yes ❑ No

Are you happy with your smile? ❑ Yes ❑ No If not, what changes would you make? _____

Would you like whiter teeth? ❑ Yes ❑ No

Would you like fresher breath? ❑ Yes ❑ No

If you need to cancel or reschedule your appointment please call 48 hours in advance.

MEDICAL ALERT

Time 10:49 AM

Gustafson Dental

Eaglesoft Medical History(Copy)

Date 5/1/2019

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes
Do you have problems sleeping or ever been told you have Sleep Apnea?	◯ Yes ◯ No	

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third party payers

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested, but if you agree then you are bound to abide by such restrictions.

Patient Name _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of privacy Practices Acknowledgement, But was unable to do so as documented below:

Date:_____ Initials _____Reason _____

Financial Policy

Thank you for choosing Gustafson Dental as your dental office. We look forward to providing quality dental care for you and achieving the maximum oral health that you deserve. The following statement is our financial policy, which we require you to sign prior to any and all treatment. This will become part of your payment record in our office.

YOUR COPAY AND OTHER ESTIMATED CHARGES THAT YOUR INSURANCE DOES NOT COVER ARE DUE AT THE TIME OF SERVICE, WE ARE UNABLE TO DETERMINE WHAT BENEFITS HAVE BEEN PURCHASED FOR YOU BY YOUR EMPLOYER OR YOUR SPOUSES EMPLOYER.

WE ACCEPT CASH, CHECK, CREDIT CARDS (MASTER CARD/VISA/DISCOVER/AMERICAN EXPRESS) AND DEBIT CARDS. OUR OUTSIDE FINANCING COMPANY IS CARE CREDIT AND WITH PRIOR APPROVAL, YOU COULD POSSBILY QUALIFY FOR AN INTREST FREE LOAN.

Regarding insurance

As a courtesy to our patients, Gustafson Dental will file a claim for you. Dental claims are normally sent electronically to avoid delays. If the insurance company has not processed and paid the claim within 45 days from the date of filing the claim or has denied the claim, the payment of the account in full then becomes the responsibility of the patient. Payment is then due within 30 days from the statement date.

Assignment of Benefits

It is the patient's/member's responsibility to be familiar with and understand their benefits. It would be impossible for us to be familiar with every individual policy. We ask that you contact your insurance company to confirm coverage for specific procedures. We will assist you in this task when possible. If ever an after hour's visit becomes necessary, an additional co pay is required. A signature is required for assignment of Insurance Benefits

Please Sign: _____ Date: _____

Missed appointments

Unlike a medical doctor's office we schedule only one patient for an allotted time. We reserve the chair for you and we value your time. We request you place the same importance on the scheduled appointment. If it becomes necessary to alter your scheduled appointment, please give us the courtesy of calling 48 hours in advance.

Signature:_____ Date: _____

Print Name: _____ Date: _____