"...Relax and Treat Yourself to the Dentistry You Deserve"

About You

Today's Date:_____ E-mail:_____

Name:_____ I prefer to be called:_____

Male / Female Birth Date: ___/___/_____ Age:_____ Social Security #:_____-____-_____

Please circle one: Single / Married / Divorced / Widowed / Separated

Home Address:_____

Street & Apartment Number City State Zip

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____ Work Phone: (____)_____-_____Ext:_____

Where and When are best times to reach you?_____

Who may we thank for referring you?_____

Other family members seen by us: _____

Employer:_____ How long? _____ Occupation:_____

Employer's Address:_____

Emergency Contact person

Name:_____ Relation:_____

Work Phone:(____)_____-_____ Home Phone:(____)_____-_____ Cell Phone:(____)_____-_____

Responsible Party Information

Name:_____ Relation:_____

Work Phone #:(____)_____-_____Home Phone #:(____)_____-_____

Home Address:_____

Street & Apartment Number City State Zip

Primary Dental Insurance Information

Insurance Company:_____Phone #:(____)_____-_____

Group #: (Plan, Local or Policy #):_____ Effective Date: _____

Insurance Co. Address:_____

Insured's Name:_____ Insured's Social Security #:_____-____-_____

Insured's Birthdate: ___/___/_____ Relationship to patient:_____

Insured's Employer:_____

Employer's Address:_____

Secondary Dental Insurance Information

Insurance Company:_____Phone #:(____)_____-_____

Group #: (Plan, Local or Policy #):_____ Effective Date: _____

Insurance Co. Address:_____

Insured's Name:_____ Insured's Social Security #:_____-____-_____

Insured's Birthdate: ___/___/_____ Relationship to patient:_____

Insured's Employer:_____

Employer's Address:_____

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists.

_____ _____

Signature of Patient / Parent or Guardian Date

Financial Policy

Our Promise to You: "***Deliver the finest in dental service, in the most caring manner."***

To assist with the investment in your dental health the following options are available so that you may choose the plan best suited for you.

Insurance:
As a courtesy, we will prepare and submit your insurance claim form. We will also provide an *estimate* which will show the expected insurance reimbursement and estimated patient portion due for each procedure. Your patient **estimated** portion will be due at the time of treatment. ***Should no payment be made by the insurance company within 45 days of service, the entire fee will be due and payable and is your sole responsibility.***

Payment Options

CASH – In lieu of insurance, Personal check, money order, cashier's check, and cash are considered "cash". A 5% courtesy is offered for cash payment of services in full on or before time of service for amounts of up to $1000, and a 10% courtesy of $1,000 or more. Insufficient fund checks null the 5% courtesy and incur a $35 service fee.

CREDIT CARD – Visa, MasterCard, American Express and Discover Card are accepted as payment for dentistry as your limit allows.

Conveniently Monthly Payment Plan Options - offered by Care Credit®

*** 6 months NO INTEREST for amounts of $300 or more.**
*** 12 months NO INTEREST for amounts of $1000 or more.**
*** 24, 36, 48 Months with Low Fixed Interest for $2500 and above**
*** 60 months with Low Fixed Interest for $3500 and above.**

APPOINTMENT RESPONSIBILITY – Because your time and Dr. Gonzales' time are of great value, To cover practice loss a **$75 fee per hour of treatment scheduled** will be assessed to your account for missed or cancelled appointments more than 2 times in a calendar year without 24 hours notice. Cancellations must be made ***during business hours and 24 hours*** prior to your scheduled appointment time. Cancellations after hours and during the weekend will still be assessed a $75.00 fee per hour scheduled. This will allow us to assist other patients that are awaiting an appointment time.

I understand that I am responsible for payment of services.
I understand my appointment responsibility and the associated fees.
I understand the payment options available to me.

_____ _____
Signature Date

Acknowledgment of Receipt of Notice of Privacy Policy

I, _____ have received a copy of this
(Printed name)
Office's Notice of Privacy Practices.

_____

(Signature)

Date: _____

****You May Refuse to Sign this Acknowledgement****

_____

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)

_____
_____
_____

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Today's Date:_____

Medical

Name:_____DOB:_____ Phone Number:_____

Address:_____City_____Zip_____

Physician Name: _____ Physician Phone:_____

Are you currently under the care of a physician? Yes / No

If "Yes", please explain: _____

Are you currently pregnant, trying to become pregnant, or nursing? Yes / No

Current AND Past Health Conditions – Circle ALL that apply:

Heart Failure	Artificial Prosthesis	Fainting / Dizzy Spells	Sinus Trouble
Heart Disease or Attack	Anemia	Nervousness	Allergies / Hives
Chest Pain	Stroke	Clinical Depression	Diabetes
High Blood Pressure	Kidney Trouble/Disease	Psychiatric Treatment	Thyroid Disease
Heart Murmur	Hepatitis	Sickle Cell Disease	Arthritis
Mitral Valve Prolapse	Liver Disease	Glaucoma	Cortisone Therapy
Rheumatic Fever	Yellow Jaundice	Chemotherapy	Pain in Jaw Joints
Heart Defects	Blood Transfusion	Cancer / Leukemia	HIV Positive / AIDS
Scarlet Fever	Drug Addiction	Venereal Disease	Loss of Appetite
Artificial Heart Valve	Alcoholism	Bruise Easily	Loss of Sleep
Heart Pacemaker	Hemophilia	Emphysema	Smoking
Heart Surgery	Fever Blisters	Asthma	Rapid Weight Loss
Artificial Joints	Epilepsy or Seizures	Hay Fever	Rapid Weight Gain

Medications / Allergies

Circle ANY and ALL of the medications you are allergic to or that have caused reactions:

Aspirin	Local Anesthetic (commonly called Novacaine)		Valium	Nitrous Oxide
Codeine	Percodan	Penicillin	Erythromycin	Sulfa

List any other medications that have caused a bad reaction or allergy: _____

List all medications that you are currently taking: _____

Circle ALL that apply:

Fear / Hate dental treatment	Cold sores / Fever blisters	Jaw pops or clicks
Bad breath / halitosis	Food sticks or gets caught	Use teeth as "tools"
Gums bleed easily or are tender	Sore / Tired Jaws	Dislike the look of my smile
Sensitive teeth	Grind / Clench teeth	

Consent

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize G dental studio and/or their trained staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize G dental studio and/or their trained staff to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk.

_____ _____

Signature of Patient / Parent or Guardian Date