PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____Middle Initial: ____

Preferred Name:_____

Patient is: □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name:_____ Last Name:_____Middle Initial:____

Address: _____ Address 2:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Birth date:_____Social Security #:_____Drivers Lic#:_____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: _____ Address 2:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____Social Security #:_____Drivers Lic#:_____

E-mail:_____ □ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Dentist:_____Preferred Hygienist:_____
Preferred Pharmacy:_____

Referred By:_____

Medicaid ID:_____

Primary Insurance Information:

Name of Insured:_____Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID:_____

Insured Social Security #: _____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____

Secondary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID:_____ Carrier ID:_____

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address: _____

Address 2: _____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____

GAITHER PERIO
DENTAL HISTORY

Dental History

What is the reason for your visit today? _____

_____

Date of last Dental Visit? _____ Last Cleaning? _____ Last set of X-rays? _____

What was done at your last visit? _____

Current Dentist's Name? _____ Telephone? _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are you currently using any fluoride products? **Y or N**

What other dental aids do you use (Interpak, toothpick, etc.)? _____

Are any of your teeth sensitive to:

Hot or cold?..... **Y or N**

Sweets? ..... **Y or N**

Biting or chewing? ..... **Y or N**

Have you noticed any mouth odors
Or bad taste?..... **Y or N**

Do you frequently get cold sores
Blisters or any other lesions?..... Y or N

Have your parents experienced gum disease
Or tooth loss?..... Y or N

Have you noticed any loose teeth or change in
Your bite?..... Y or N

Do You:

Clench or grind your teeth while awake
Or asleep?..... Y or N

Bite your lips or cheeks regular.....Y or N

Hold foreign objects in your mouth
(pencils, pipe, nails, etc.) ..... Y or N

Mouth breathe while wake or asleep?..... Y or N

Have tired jaws especially in the morning? Y or N

Snore or have any other sleeping
Disorders?..... Y or N

Do you use Tobacco products?..... Y or N

If yes, what type and how often_____
_____.

Have you ever had:

Periodontal treatment?.....**Y or N**

If yes, what type and when? _____

_____

Your teeth ground or bite adjusted?..... Y or N
A bite plate or mouth guard?..... Y or N
A serious injury to the mouth or head?..... Y or N
If yes, please explain? _____
_____

Have you ever experienced:

Clenching or popping of the jaw?..... Y or N
Pain (joint, ear, side of face)?..... Y or N

Difficulty in opening or closing mouth?... Y or N

Difficulty in chewing on either side of
the mouth?..... Y or N

Headaches, neck aches or shoulder
aches?..... Y or N

Would you like to keep all your teeth all
all your life?..... Y or N

Have you ever been told to pre- med prior
to dental treatment?..... Y or N

If yes, explain_____
_____.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

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

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

_____

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 _____ DATE _____

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Preferred Name:

Patient is : ¡ Responsible Party ¡ Policy Holder

Responsible Party: (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security #: Drivers Lic#:

Ë Responsible Party is Policy Holder for Patient Ë Primary Policy Holder Ë Secondary Policy Holder

Patient Information:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Sex: Ë Female Ë Male Marital Status: Ë Married Ë Single Ë Divorced Ë Separated Ë Widowed

Birth date: Social Security #: Drivers Lic#:

E-mail: ¡ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: Ë Full Time Ë Part Time Ë Self Employed Ë Retired Ë Unemployed

Student Status: ËFull Time Ë Part Time

Preferred Dentist: Preferred Hygienist: Preferred Pharmacy:

Referred By:

Medicaid ID:

Primary Insurance Information:

Name of Insured: Relationship to Insured: ËSelf ËSpouse ËChild Ë Other

Employer ID: Carrier ID:

Insured Social Security #: Insured Birth date:

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Secondary Insurance Information:

Name of Insured:	Relationship to Insured: ËSelf ËSpouse ËChild Ë Other
Employer ID:	Carrier ID:
Insured Social Security #:	Insured Birth date:
Employer:	Insurance Company:
Address:	Address:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:

GAITHER PERIO
HIPAA AND PHOTOGRAPHY CONSENT

In General, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

We are dedicated to helping you maintain and enjoy a healthy smile for a lifetime! We will explain and discuss treatment cost prior to procedures. Treatment recommendations at this office are made to improve your oral health and accomplish your health goals.

During your treatment, photographs and/or video may be taken. I authorize that these photographs and/ or videos can be used for diagnostic and teaching purposes.

By signing below, I acknowledge that I have read and understand the above information and have had any specific questions answered. I agree to accept correspondence from this office through any given contact information, including messages. I authorize the office to send my insurance carrier any necessary information about my condition so that prompt and accurate payment can be made. I also authorize my insurance company to make payment directly to this office. This authorization will remain in effect until I notify the office in writing otherwise.

Privacy Statement- This office shares no information with anyone outside the office regarding your dental or medical condition. Only when appropriate for your care will we discuss your treatment with your other medical professionals or authorized family members.

Signature of patient, parent, or guardian (responsible party)

_____Date: _____

Relationship to Patient_____

Person/s whom we may discuss your treatment and health

_____

GAITHER PERIO
INSURANCE AND BILLING CONSENT

Insurance and Billing Practices

Please read the following about our policies regarding billing practices for your dental insurance.

It is your responsibility to:

- Provide Gaither Perio and Dental Implants with accurate information regarding your insurance, employer, date of birth, and social security number to facilitate billing your insurance. This information is included on the Patient Registration Form included in your new patient packet. Gaither Perio and Dental Implants respects your right to privacy and will maintain the confidentiality of your information.
- Understand your insurance benefits regarding which company your dental coverage is through, co-pays, and maximums. If you are not certain about your insurance coverage, please investigate this before you arrive for your appointment. Gaither Perio and Dental Implants accepts payments by cash, check, and all major credit cards. There is a $30.00 fee for returned checks.
- Pay for any service or procedure not covered by your insurance carrier. Costs for dental services and non- dentally indicated procedures not covered by insurance will be discussed with you before they are performed.
- Obtain insurance referrals from your General Dentist if your insurance requires it. Please check with your General Dentist or your insurance before your appointment to guarantee your referral is in place.
- Have your insurance card or insurance information with you on arrival for your appointment. If you do not have proof of insurance, you will be asked to pay for your visit.
- Pay Gaither Perio and Dental Implants for dental services not paid by your insurance carrier, including claims denied because of information you provided to us was not complete.

It is our responsibility to:

- Submit claims to your insurance carrier for the dental service we provide during your visit.
- Provide your insurance company with the information necessary to determine the dental care you received during your visit.
- Submit claims to your secondary insurance plans at your request. If we do not receive payments within 60 days, we will issue you a bill for the services provided.

If Gaither Perio Dental Implants is not covered due to your insurance policy, you will have to pay for your visit and any services rendered at the time of your appointment. Gaither Perio and Dental Implants offers reasonable rates for patients who pay for dental services on their own.

If you do not pay your bills from Gaither Perio and Dental Implants in a timely fashion, you will be notified in writing and your bill will be referred to an outside collection agency or pursued through legal proceedings. You will be responsible for all costs associated with the collection agency plus the fees owed to us.

Please be courteous and cancel or reschedule any appointments within 24 hours if you are unable to keep your appointment. In the event you have a no- show or call to cancel an appointment within 24 hours if your appointment time, we will request a $20.00 fee for you to schedule another appointment, this $20.00 fee will be charged to your credit card when you call for an appointment and apply to your account balance upon arrival for your appointment. In the event you again do not show or cancel our appointment within 24 hours, we will retain this $20.00 fee as payment for no-show appointment. This fee will not then apply towards your co-payment or account balance at future appointments.

I certify I have read the above information and all my questions answered. I understand and agree to the policies described above. I understand I am responsible for charges not covered by my insurance.

Signature_____ **Date** _____