GULCH DENTAL STUDIO

How Did You Hear About Us? ◯ Referral (who may we thank):_____
◯ Internet Search ◯ Other:_____

Patient's Name:_____ Birth Date: ____|_____|_____ ◯ Female ◯ Male

Address:_____

City:_____ State:_____ Zip Code:_____ ◯ Single ◯ Married ◯ Widowed

Home #: _____ Work #:_____ Cell #: _____

Patient SSN:_____ -- _____ --_____ Email Address: _____

Do You Live or Work In The Gulch? ◯ Yes ◯ No

Employed by / Student at (circle one): _____

Person responsible for this Acct:_____ SSN of Responsible Party:_____

Emergency Contact:_____ Phone: _____ Relation:_____

CHECK ALL THAT APPLY TO YOU:

Diabetes	◯ Yes	◯ No
Infective Endocarditis	◯ Yes	◯ No
Congenital Heart Condition	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No
High Blood Pressure	◯ Yes	◯ No
Rheumatic Fever	◯ Yes	◯ No
Liver Disease	◯ Yes	◯ No
Abnormal Heart Condition	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No
AIDS / HIV	◯ Yes	◯ No
Kidney Disease	◯ Yes	◯ No
Pregnant/nursing	◯ Yes	◯ No
Oral Contraception	◯ Yes	◯ No
Stroke	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No
Stent	◯ Yes	◯ No
Tuberculosis	◯ Yes	◯ No
Hepatitis: A, B, C, D	◯ Yes	◯ No
Jaundice	◯ Yes	◯ No
Respiratory Problems	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No
Asthma	◯ Yes	◯ No
COPD	◯ Yes	◯ No
Sinus Problems	◯ Yes	◯ No
Hay Fever	◯ Yes	◯ No

CHECK ALL THAT APPLY TO YOU:

Blood Transfusion	◯ Yes	◯ No
Lupus	◯ Yes	◯ No
Sjogren's Syndrome	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No
Blood Disorders	◯ Yes	◯ No
Abnormal Bleeding	◯ Yes	◯ No
Anemia	◯ Yes	◯ No
Fainting	◯ Yes	◯ No
Dizziness	◯ Yes	◯ No
Seizures	◯ Yes	◯ No
Epilepsy	◯ Yes	◯ No
Nervous Disorders	◯ Yes	◯ No
Mental Disorders	◯ Yes	◯ No
Venereal Disease	◯ Yes	◯ No
Recurrent Illness	◯ Yes	◯ No
Slow Healing/Mouth Sores	◯ Yes	◯ No
Osteoporosis	◯ Yes	◯ No
Osteopenia	◯ Yes	◯ No
Cancer	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No
Radiation Therapy	◯ Yes	◯ No
Drink Alcohol?	◯ Yes	◯ No
_____ drinks/week		
Tobacco	◯ Yes	◯ No
____ Cigarette Packs /week		
____ Smokeless Cans/week		

DO YOU HAVE A HISTORY OF:

Acid Reflux	◯ Yes	◯ No	Heart Burn	◯ Yes ◯ No
Vomiting	◯ Yes	◯ No	Morning Sickness	◯ Yes ◯ No

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PLEASE LIST ALL CURRENT MEDICATIONS:

_____ _____

_____ _____

_____ _____

_____ _____

Have You Ever Been Treated for Periodontal Disease? *(e.g. gum disease, periodontitis)* ◯ Yes ◯ No

Have You Ever Had Replacement Surgery**? (**e.g. Hip, Knee, etc) ◯ **Yes** ◯ **No**

Have You Previously Taken Antibiotic Pre-Medications Before Dental Procedures? ◯ Yes ◯ No

Name Of Previous Dentist: _____ Phone:_____

May We Request Your Dental Records & X-rays? ◯ Yes ◯ No

Date Of Last Bitewing X-rays:_____|_____|_____ Date Of Last Panoramic X-ray:_____|_____|_____

ARE YOU ALLERGIC TO OR EXPERIENCED A REACTION TO THE FOLLOWING?

Local Anesthetic (e.g. Novocaine)	◯ Yes ◯ No	Penicillin / Other Antibiotic	◯ Yes ◯ No
Latex	◯ Yes ◯ No	Aspirin /Codeine	◯ Yes ◯ No
Barbiturates / Sedatives	◯ Yes ◯ No	Sleeping Pills	◯ Yes ◯ No
Sulfa Drugs	◯ Yes ◯ No	Other Allergies	◯ Yes ◯ No

Please List Other Known Allergies _____

_____

_____

ARE YOU HAPPY WITH YOUR SMILE?

Would you like to discuss anything in particular with Dr. Trembley or Dr. Newman concerning your smile?

◯ Yes ◯ No

Are you happy with your smile?

◯ Yes ◯ No

CHECK ALL THAT APPLY:

Are You Interested In Botox Therapy	◯ Yes ◯ No
In-Office Teeth Whitening	◯ Yes ◯ No
TMJ Therapy	◯ Yes ◯ No
A Cosmetic Consultation	◯ Yes ◯ No
Do You Experience Tooth Sensitivity	◯ Yes ◯ No

We love to know about our patients. Share something interesting about yourself below!

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DENTAL INSURANCE INFORMATION (Please DO NOT list your Medical Insurance)

PRIMARY INSURANCE

Name of Insured: (First) _____ (Last) _____ (MI) _____

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

Insured's Social Security #: _____ -- _____ -- _____ Insured's Employer: _____

Patient's Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other: _____

Insurance Plan Name: _____

Insurance Plan Address: _____

Insurance Plan Phone #: _____

SECONDARY INSURANCE

Name of Insured: (First) _____ (Last) _____ (MI) _____

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

Insured's Social Security #: _____ -- _____ -- _____ Insured's Employer: _____

Patient's Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other: _____

Insurance Plan Name: _____

Insurance Plan Address: _____

Insurance Plan Phone #: _____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT

X: _____ Date: _____ | _____ | _____

(Signature of Patient or Guardian)

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GULCH DENTAL STUDIO

OUR FINANCIAL POLICY

All patients without dental insurance will be required to pay for services at the time services are rendered. We accept cash, personal checks, and for your convenience MasterCard, Visa and Discover.

For all patients with dental insurance, we will process your insurance claim for your reimbursement as long as we have complete insurance information.

Please keep in mind your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company. All charges are your responsibility whether your insurance company pays or not. Please be aware that not all services are covered benefits in all dental contracts. You are responsible for the knowledge of coverage of your dental policy.

If your insurance company does not pay toward your claim within 45 days of date of service, we will require you pay the balance due.

Please note that if you are given a financial estimate of your services prior to service being rendered that is ONLY AN ESTIMATE of charges. It is possible that your dental insurance may pay less than or more than was estimated.

Balances older than 60 days will be subject to finance charges of 1.5% per month on the unpaid balance of 18% annum. Returned checks will have an additional fee of $30.00 added to the amount of the returned check.

In the event that your account becomes past due, you agree to be responsible for all costs of collection including reasonable attorney fees and court costs

Patient Name: _____

Patient Signature: _____ Date: _____ | _____ | _____

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CANCELLATION POLICY

Dr. Clint Newman and Dr. Jeff Trembley are committed to your health. When you miss an appointment, other patients are unable to take your place and are delayed unnecessarily. If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance. Please call as soon as possible so that another patient can be given your appointment.

Our office tracks missed appointments. A "no show" or "late cancellation" is defined as missing or rescheduling an appointment without giving 24 hours of advanced notice. There will be a $75.00 charge for a missed appointment. Insurance will not cover charges for "no show" or "late cancellation" fees. This charge is in addition to any other charges you may have incurred.

Unfortunately, repeated missed appointments may result in a letter discharging the patient from the practice. Dr. Newman and Dr. Trembley understand that emergencies will occur and consideration will be made for missed or "no show" appointments.

By signing below, you state that you have been notified and understand this policy.

X: _____ Date: _____ | _____ | _____

(Signature of Patient or Guardian)

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PRIVACY PRACTICE POLICY

I have read and reviewed the Notice of Privacy Practices Policy (effective on September 23, 2013). I acknowledge that I am entitled to receive a more complete description of the uses and disclosures of my health information at my request. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of the Notice of Private Practices.

Patient Signature: _____

Print Patient Name: _____ Date: _____ | _____ | _____

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