



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

**CHECK ALL THAT APPLY TO YOU:**

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

**DO YOU HAVE A HISTORY OF:**

Acid Reflux	<input type="radio"/> Yes <input type="radio"/> No	Heart Burn	<input type="radio"/> Yes <input type="radio"/> No
Vomiting	<input type="radio"/> Yes <input type="radio"/> No	Morning Sickness	<input type="radio"/> Yes <input type="radio"/> 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) | <input type="radio"/> Yes <input type="radio"/> No | Penicillin / Other Antibiotic | <input type="radio"/> Yes <input type="radio"/> No |
| Latex                             | <input type="radio"/> Yes <input type="radio"/> No | Aspirin /Codeine              | <input type="radio"/> Yes <input type="radio"/> No |
| Barbiturates / Sedatives          | <input type="radio"/> Yes <input type="radio"/> No | Sleeping Pills                | <input type="radio"/> Yes <input type="radio"/> No |
| Sulfa Drugs                       | <input type="radio"/> Yes <input type="radio"/> No | Other Allergies               | <input type="radio"/> Yes <input type="radio"/> No |

Please List Other Known Allergies \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ARE YOU HAPPY WITH YOUR SMILE?**

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

Yes  No

Are you happy with your smile?

Yes  No

**CHECK ALL THAT APPLY:**

- |                                     |  |
|-------------------------------------|--|
| In-Office Teeth Whitening           | <input type="radio"/> Yes <input type="radio"/> No |
| TMJ Therapy                         | <input type="radio"/> Yes <input type="radio"/> No |
| A Cosmetic Consultation             | <input type="radio"/> Yes <input type="radio"/> No |
| Do You Experience Tooth Sensitivity | <input type="radio"/> Yes <input type="radio"/> 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)



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. Scott Harris 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. Harris 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: \_\_\_\_ | \_\_\_\_ | \_\_\_\_