Welcome

Guthrie DENTISTRY

Patient Information

Date: _____

Name _____ SSN _____
Address _____
City _____ State _____ Zip _____
Birthdate _____ Home Phone _____
Cell Phone _____ Email _____
Preferred Contact Method: Phone Call: □Home Phone □Cell Phone □ Text Message □ Email
Check Appropriate Box: □ Minor □ Single □ Married □ Separated □ Divorced □ Widowed
How did you hear about us? _____
If Referred, whom may we thank for referring you? _____
Responsible Party _____ Relationship to patient _____

***Payment is expected at the time services are rendered unless insurance coverage has been established and discussed. If other arrangements are necessary, fees should be discussed prior to treatment.**

Cash/Check **Fulfill Insurance Requirements** **Visa/MasterCard/Discover**

CareCredit **Need to Discuss**

Insurance Information (please present card to front desk)

Name of Insured _____ Relationship to patient _____
Insurance Company _____ Birthdate _____ SSN _____
Name of Employer _____ Work Phone Number _____
Employer address _____City _____State _____ Zip _____
Do you have additional Insurance? □Yes □No If yes, present additional insurance information to front desk

Dental History

Name of Previous Dentist _____ Date of last dental visit _____

Do your gums bleed while flossing? □Yes □No
Are your teeth sensitive to hot and/or cold? □Yes □No
Do you have any sores or lumps in or near your mouth? □Yes □No
Have you experienced any clicking, pain (joint, ear, side of face) difficulty opening/closing, difficulty chewing? □Yes □No
If Yes, please list all that apply
_____
Do you clench or grind your teeth? □Yes □No
Have you had any orthodontic treatment in the past? □Yes □No

Do you have city or well water? □Yes □No
Do you wear a denture or partial? □Yes □No
If yes, date of placement _____
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? □Yes □No
Do you feel pain to any of your teeth? □Yes □No
Do you like your smile? □Yes □No
Do you have any problems with your teeth you would like your dentist to address? □Yes □No
_____

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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ 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	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 Problem ◯ 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 _____

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 _____

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.
The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: _____
Printed Name-Patient or Responsible Party

_____
Patient Signature or Responsible Party Date

_____
Relationship to patient (if other than patient)

Witness: _____
Printed Name-Practice Representative

_____ _____/_____/_____
Signature Date

Request to Release Dental Records

Patient's records/ X-rays are requested to be released to:

Guthrie Dentistry Inc.

I authorize and request the release of my dental records from:

_____

Name: _____

Address: _____

_____

Date of Birth: _____

Signature: _____

Relationship: _____

Please Email current x-rays to: office@guthriedentistry.com

Thank you!

Guthrie
DENTISTRY

Financial Policy Acknowledgment

Welcome to Guthrie Dentistry! We are committed to providing you with exceptional dental care. As a condition of your treatment by our office, financial arrangements must be made in advance. For your convenience, we accept cash, checks, Visa, MasterCard, and Discover. Additionally, we partner with Care Credit to offer extended payment plans with no interest during the promotional period. Generally, **payment is due at the time services are rendered**.

Payments made by check that are not honored by the bank will incur a returned check fee of $45.00. If you have a balance on your account that is past **90 days** the account holder may be referred to collections for payment, and subsequently reported to the credit bureaus.

If you have dental insurance, we will certainly work with you to help get the maximum benefit available to you**. You will be expected to pay your deductible, co-pays, coinsurance, and fees for any non-covered services on the day services are rendered. We cannot guarantee any estimated charges, as your insurance company determines benefits payable upon receipt and processing of claims**. Your signature on this form provides authorization for your insurance company to pay benefits directly to our office.

Please ensure you inform us of any changes to your insurance plan(s) prior to your appointment or at check-in, and allow us to make a copy or scan your insurance card(s) when available.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I grant my permission to you or your assignee, to contact me via any method provided to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to the contents.

_____

Print Name

_____ _____

Signature Date