



Welcome to Gage Dental

Patient Information

Date: _____

Name _____ Preferred Name _____
Last First M.I.

SSN _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Email _____ Preferred Contact: Home Cell Work

Sex: ___ Female ___ Male Circle One: Married Single Divorced Widowed

Employer _____ Occupation _____

Who should we thank for referring you? Newspaper Internet Patient Sign Other: _____

Emergency Contact _____ Phone _____

Responsible Party (for minors)

Name _____

SSN _____ DOB _____

Address _____ City _____ State _____ Zip _____

Primary Dental Insurance

Person Responsible for Account

_____ Last First M.I.

Relationship to Patient _____

DOB _____ SSN _____

Insurance Company _____

Phone _____

Policy Holder _____

Subscriber ID _____ Group _____

Policy Holder SSN _____ Policy Holder DOB _____

Employer _____

Phone _____

Additional Insurance

Person Responsible for Account

_____ Last First M.I.

Relationship to Patient _____

DOB _____ SSN _____

Insurance Company _____

Phone _____

Policy Holder _____

Subscriber ID _____ Group _____

Policy Holder SSN _____ Policy Holder DOB _____

Employer _____

Phone _____

Dental & Health History

Name _____

Please check any of the following that apply:

- Sensitivity (hot, cold, sweet, pressure)
- Headaches, earaches, neck pain, Jaw Joint Pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad Breath
- Smoke/chewing tobacco
_____ How much _____ How long

Do you have any of the following?

- Dentures/Partial Denture
- Braces
- Periodontal (gum) treatments

What is most important about your dental visit today?

Previous Dentist _____

Phone Number _____

Date of Last Cleaning _____

Physician Name _____

Phone Number _____

Medical History

Please check any of the following problems/conditions that apply to you:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Dizziness	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Allergies (seasonal)	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> HPV (Human Papilloma Virus)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Angina (chest pain)	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Jaw Joint Pain	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Lesions (Congenital)	<input type="checkbox"/> Nervousness/Depression	<input type="checkbox"/> Venereal Diseases
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Other (please explain below)
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Pregnant Currently	
<input type="checkbox"/> Cervical Cancer	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Radiation (head/neck)	
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Respiratory Problems	
<input type="checkbox"/> Cortisone Medication	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatism	

Are you allergic or have you reacted adversely to any of the following medications?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Percodan	<input type="checkbox"/> Valium	<input type="checkbox"/> Darvon	<input type="checkbox"/> Latex	<input type="checkbox"/> Codeine
<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other _____

Medications Currently taking: _____

Are you currently under a physician's care? What for? _____

Consent:

The undersigned hereby authorize Gage Dental to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Gage to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Gage to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature (parent if child)

Date



Financial Policy

Thank you for choosing Dr. Gage as your dental provider. We are committed to providing excellent dental services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

ALL PATIENTS MUST READ AND SIGN THIS FORM PRIOR TO RECEIVING SERVICES.

1) You are financially responsible for your account.

--We will process your insurance as a courtesy to you.

--35% of no surgical and surgical treatment, along with unpaid deductibles and co-payments are due at the time of treatment. A statement will be sent for balances that remain if your dental

benefit

pays less.

--All charges are your responsibility whether your insurance company pays or does not pay. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

-- If the insurance company does not pay your claim after 60 days, a statement will be sent for the full balance, which will be due and payable at that time.

--I understand that employees of Gage Dental are NOT representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance carrier.

--A dental benefit plan is an agreement between you, your employer and the insurance company.

It is your responsibility to know and understand the level of services covered by your insurance company. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payment, covered charges, secondary, and "usual and customary charges." We charge the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

--I authorize payment from my insurance carrier to be made directly to the dentist. If payment is sent to me from the insurance company; I will forward it directly to the dentist, as it is a theft of professional services if I keep the money. This is punishable by law and the account will be sent directly to collections.

2) It is your responsibility to provide us with your most current billing information.

--Payment in full is due upon receipt of a statement, unless other arrangements have been made.

Balances older than 90 days may be subject to collection placement and fees or small claims court.

Interest at 18% will begin to accumulate after 90 days. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.

--We understand that temporary financial problems and situations arise. We encourage you to communicate any such problems, so we may assist you in management of your account.

3) Cancellation: Kindly give 24 business hours notice if you must cancel an exam or office visit. 48 hours (two business days) are required if you must cancel a surgical procedure. If not, a fee will be incurred.

4) Lateness: If you are running late, kindly give us a phone call. If you are more than ten minutes late, we will try to accommodate you, but please understand that we may need to reschedule the appointment. A fee may be assessed if the problem is recurrent.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, CREDIT CARD, AND APPROVED FINANCING. I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY.

Patient or Guardian Signature

Printed Name of Patient

Date



Photographic Release

In our office we like to photograph our patients to aid Dr. Gage in determining dental problems and the solutions/treatment options for them. Dr. Gage sometimes uses the photographs, with the patients permission, to prepare presentations that teach students about dental health.

Authorization and release:

I hereby authorize Dr. Gage to use photos of my face, jaws, and teeth. I understand that the photos may be used as a record of my care and may be used for educational purposes in lectures, demonstrations, and advertising. (Including website, magazines, phonebooks, television) and professional publications. I further understand that if my photos are used in any way described above that my name and identifying information will be confidential. I do not expect compensation for use of these photos.

Patient Signature

Date

X-ray Information

X-rays provide invaluable information to Dr. Gage for diagnosing and treatment planning. To provide a comprehensive examination, x-rays are required. There are a variety of x-rays; each provides a variety of information. Dr. Gage will recommend x-rays based on your individual needs.

Our x-ray system is digital which results in the lowest possible exposure to radiation. We are able to view the films immediately.

Insurance companies limit the types and the frequency that some x-rays are taken. It is our responsibility to provide a comprehensive evaluation to you. By limiting the allowance of x-rays Dr. Gage cannot present a complete evaluation to you. If there are x-rays recommended to you that are declined, we will require a signed release of liability from you stating that you fully understand that there are conditions that cannot be diagnosed without them.

I have read the information regarding x-rays and fully understand Dr. Gage's philosophy. I understand that my insurance company limits frequency of some types of x-rays and if I am in a situation that requires services not covered, I will be responsible for the fees associated with the service.

Patient Signature

Date



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****You may refuse to sign this form*****

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that Gage Dental reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy upon request. I may request a copy of the updated Notice of Privacy Practices by calling Dr. Gage's office or requesting a copy in person at my appointment.

Print Name

Date

Signature

Witness

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for John L . Gage, D.D.S. to share my protected health information with:

Name

Relationship

Name

Relationship

Name

Relationship

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgment could not be obtained because:

- Individual refused to sign _____
- Communication barriers prohibited obtaining the acknowledgement _____
- An emergency situation prevented us from obtaining acknowledgement _____
- Other (Please Specify)
