Patient Information

Name: _____ **Address:** _____
Last First MI

City:_____ **State:** _____ **ZIP:** _____ **Employer:** _____

Sex: _____ **Phone (H)**: _____ **(W)** _____ **(Cell)** _____

Date of Birth: _____**Driver's License #:**_____**Soc Sec#** _____

Family Status: ☐ Single ☐ Married (Name of Spouse: _____) ☐ Child ☐ Other

Email address: _____ **Do you check your email 3 or more times a week? Yes No**

Parent or Guardian's Name (if patient is a minor): _____

Whom may we thank for referring you to our office? _____

DENTAL INFORMATION—place an "X" next to any condition you have experienced.

___ Have you ever had complications from past dental treatment?
___ Have you ever had trouble getting numb?
___ Have you ever had any reactions to local anesthetic?
___ Do you have or have ever had braces, orthodontics or bite appliances?
___ Are your teeth sensitive to hot, cold, biting or sweets?
___ Do you avoid brushing any part of your mouth?
___ Does food get trapped between any of your teeth?
___ Have you ever whitened or bleached you teeth?
___ Have you experienced popping and/or clicking of your jaw joint?
___ Do you clench or grind your teeth?
___ Do your gums bleed when you brush or floss?
___ Have you been treated for gum disease or told you have lost bone around your teeth?
___ Have you noticed an unpleasant taste or odor in your mouth?
___ Have you had abnormal bleeding from previous extractions, surgery, or trauma?
___ Have you had surgery, xray, or drug treatment for a tumor, growth, or other condition of your head or neck?

If you checked any of the above items in Dental Information, <u>please explain further</u>:

_____

_____

What is your immediate dental concern that prompted you to call for an appointment?

_____

Is there anything about the appearance of your smile that you would like to change?

_____

For Patients with Dental Insurance: Insurance Authorization

- I authorize my insurance company to pay the dentist for all insurance benefits rendered.
- I authorize the use of my signature (either manual or electronic) on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

*_____ _____

Signature Date

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that I have provided true and accurate information to the best of my knowledge. I will not hold Dr. Guebert or any member of his staff responsible for any errors or omissions that may have been made in the completion of this form.

I understand that I am financially responsible for any outstanding balance for services. I understand that I will be billed for any remaining balance that may occur if my dental insurance does not cover as estimated. I consent and agree to be financially responsible for payment of all services on my behalf or on behalf of my dependents (if any).

*_____ *_____ _____

Name Printed Signature Date

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HIPAA: Acknowledgement of Receipt of Notice of Privacy

Sometimes patients wish to give permission for a family member or someone else to talk to our office about their dental care, payment options, etc. The space below allows you to name a person if you desire.

I give permission to Dr. Guebert and any of his staff to communicate with the **BELOW NAMED PERSON(s)** to discuss and receive information on ALL aspects of my dental and overall healthcare including, but not limited to, treatment needs and options, dental conditions, appointments, all insurance concerns, and resources to obtain payment or insurance benefits. I understand that I can revoke this authorization anytime by written request:

Name and phone number of person you authorize to discuss all aspects of your dental care in our office

(OPTIONAL): _____

I acknowledge the above authorization, if applicable, and that I have received a copy of this office's Notice of Privacy Practices.

*_____ _____

Signature Date