GARDNER DENTAL

TIMOTHY A. GARDNER DMD

NEW LAYTON OFFICE – 525 N FAIRFIELD, LAYTON, UT 84041
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ABOUT YOU

Patient Full Name_____Birthdate_____SS#_____-_____-_____
(First) (MI) (Last)

Mailing Address_____City_____State_____Zip Code_____

Marital status: Minor Single Married Divorced Widowed Separated

Home #_____Cell #_____Work #_____Other #_____

E-mail_____Drivers License #_____State_____

Employer_____Occupation_____

Who may we thank for referring you to our office?_____Other family members seen by us:_____

SPOUSE INFORMATION

His/Her Full Name_____Birthdate_____SS#_____-_____-_____
(First) (MI) (Last)

Home #_____Cell #_____Work #_____Other #_____

EMERGENCY CONTACT

In the event of an emergency, who would you like us to contact?

Name_____Relationship_____

Home #_____Cell #_____Work #_____Other #_____

FINANCIAL RESPONSIBILITY

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 45 days past due, the monthly rate of 1.75%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. There will be a $35.00 charge for returned checks.

SIGNATURE_____Date_____

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of Insurance Company_____Customer Service #_____

Mailing Address_____City_____State_____Zip Code_____

Policy ID/Member #_____Group #_____Employer_____

Insured's Name_____Relationship_____Birthdate_____SS#_____-____-_____

Secondary Insurance

Name of Insurance Company_____Customer Service #_____

Mailing Address_____City_____State_____Zip Code_____

Policy ID/Member #_____Group #_____Employer_____

Insured's Name_____Relationship_____Birthdate_____SS#_____-____-_____

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ACKNOWLEDGEMENTS OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

*****You may refuse to sign this acknowledgement*****

I, _____, have received a copy of this office's Notice of Privacy Practices.

SIGNATURE_____Date_____

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

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

DENTAL HISTORY

Why have you come to the dentist today?_____

How would you describe the condition of your teeth and gums? **Excellent** **Fair** **Poor**

Previous Dentist_____ Last Visit Date_____

Y/N Do your gums bleed while brushing or flossing? Y/N Are your teeth sensitive to hot or cold liquids/foods? Y/N Are your teeth sensitive to sweet or sour liquids/foods? Y/N Do you feel pain to any of your teeth? Y/N Do you have frequent headaches? Y/N Do you clench or grind your teeth? Y/N Do you bite your lips and cheeks? Y/N Have you had difficult extractions in the past? Y/N Do you have any sores or lumps in or near your mouth?	Y/N Have you had any orthodontic work? Y/N Have you ever had prolonged bleeding? Y/N Have you ever had instruction on the correct method of brushing you teeth or care of your gums? Y/N Have you had any head, neck or jaw injuries? Y/N Have you ever experienced any of the following jaw problems: A) Clicking B) Pain (Joint, Ear, Side of Face) C) Difficulty in opening or closing D) Difficulty in chewing

MEDICAL HISTORY

Are you currently under the care of a physician? Yes/No If YES, please list reason_____

Do you have a personal physician? Yes/No IF YES, please list physician's name_____

Have you ever been hospitalized for any surgical operation or serious illness? Yes/No If YES please explain:

_____

Describe your current physical health: Excellent Fair Poor Do you smoke or use smoke-less tobacco? Yes/No

***For WOMEN: Are you taking birth control pills? Yes/No If YES, please specify_____

Are you PREGNANT? Yes/No If YES, how many weeks?_____ Are you nursing? Yes/No

Are you currently taking any of the following:

Prescriptions Over the counter drugs Herbal Supplements Appetite Suppressants

*****ARE YOU REQUIRED TO PRE-MEDICATE DUE TO ARTIFICIAL JOINTS OR OTHER MEDICAL CONDITIONS**? Yes/No

LIST ALL CURRENT MEDICATIONS

_____
_____
_____
_____

Have you ever had any of the following diseases or medical problems?

Y/N Abnormal Bleeding	Y/N Cosmetic Surgery	Y/N Liver Disease
Y/N Alcohol/Drug Abuse	Y/N Diabetes	Y/N Low Blood Pressure
Y/N Allergies (seasonal)	Y/N Emphysema	Y/N Mitral Valve Prolapse
Y/N Alzheimer's Disease	Y/N Epilepsy	Y/N Nervous Problems
Y/N Anemia	Y/N Fainting Spells	Y/N Pacemaker
Y/N Arthritis	Y/N Fever/Blisters/Herpes	Y/N Psychiatric
Y/N Artificial Joints/Bones	Y/N Frequent Headaches	Y/N Radiation
Y/N Artificial Heart Valves	Y/N Glaucoma	Y/N Rheumatic/Scarlet Fever
Y/N Asthma	Y/N Hay Fever	Y/N Seizures
Y/N Back Problems	Y/N Heart Problems	Y/N Shingles
Y/N Bleed/Bruise Easily	Y/N Heart Attack	Y/N Sickle Cell Disease
Y/N Blood Disorder	Y/N Heart Surgery	Y/N Sinus Problems
Y/N Blood Transfusion	Y/N Hemophilia	Y/N Stroke
Y/N Cancer/Chemotherapy Treatment	Y/N Hepatitis (A, B, C)	Y/N Thyroid Problems
Y/N Circulatory Problems	Y/N High Blood Pressure	Y/N Tuberculosis
Y/N Chronic Diarrhea	Y/N HIV+ or AIDS	Y/N Ulcers
Y/N Colitis	Y/N Kidney Problems	

Are you **ALLERGIC** to any of the following:

Y/N Aspirin	Y/N Erythromycin	Y/N Sulfa
Y/N Codeine	Y/N Latex	Y/N Tetracycline
Y/N Dental Anesthetics	Y/N Penicillin	Y/N Other_____

Please list any serious medical conditions that you've ever had:_____

_____

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FINANCIAL POLICY

This is an arrangement between Gardner Dental and the Patient/Guarantor. The word Guarantor refers to the responsible party. The word account means the account that has been established in your name to which the charges are made and payments credited. The words we, us and our, refer to Gardner Dental. By executing the agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will reflect a previous balance, any new charges to the account, and any payments or credit applied to your account during the month.

Payment Options if you have no insurance: Payment is expected on the day that treatment is rendered. You may pay cash, check or credit card. You may prefer to secure financing through a third party such as Care Credit. If you would like more information on this, please speak to our staff.

Payment Options if you have insurance: You will need to pay your deductible, co-payment, and any out of pocket portions at the time of service by cash, check or credit card. If you choose to pay for all of your treatment in full at the time of service, we will promptly issue a refund for any credit balance. It is your responsibility to verify coverage and eligibility with you insurance carrier prior to service.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due upon receipt. If payment is not received, we reserve the right to refuse future appointments on delinquent accounts. Any balances due after your insurance clears, for whatever reason, are your responsibility. Full payment is due upon receiving your statement from Gardner Dental unless prior arrangements have been made.

Insurance: Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. In order to properly bill your insurance, we required that you disclose all insurance information. Failure to provide complete insurance information may result In the patient responsibility for the entire bill. As stated above, Gardner Dental will bill your insurance, however, it is NOT a guarantee of payment. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Insurance companies provide and Explanation of Benefits outlining payments and patient balances.

Returned Checks: There is a $35.00 returned check fee on any checks returned by the bank. We may choose to proceed with legal action, which could result in additional fees to the patient or guarantor on the account. Additionally, we may refuse to accept check payment on your account for future services rendered.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we refer the collection of the balance to an attorney, you agree to pay all attorney's fees that are incurred, plus court costs.

Interest Charges: If you fail to pay your statement balance within 30 days of receiving it, without making arrangements, finance charges will incur at the rate of 18% APR.

I have read and agree to the terms outlined above:

SIGNATURE_____Date_____

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CONSENT TO PROCEED

I authorize Dr. Timothy A. Gardner and/or Dr. Christopher J. Dorny and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause unforeseen reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently lacerated (cut) or suffer abrasion during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient name_____

SIGNATURE_____Date_____

(Patient, legal guardian or authorized agent of patient)