



Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you use tobacco in any form? Yes No

Have you had any metal rods, pins, implants, or artificial prosthetics placed? Yes No

Are you taking any medications? Yes No

Please list each one: _____

Have you ever had any surgical procedures? Yes No

Please list each one: _____

Yes	No	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Facial Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches

Yes	No	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	Shingles

Yes	No	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers

Yes	No	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	<input type="checkbox"/>	Latex _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes	No	If Female, Please Answer
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking Birth Control Pills?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If so, # of Week _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?

Nearest relative not living with you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____



Dental History

How may we help you today? _____

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you had any pain/discomfort in your joint? (TMJ) Yes No

Are you under stress? (new job, moving, relationships) Yes No

Do you like your smile? Yes No

Is there anything you would like to change about your smile? Yes No

Are you happy with the color of your teeth? Yes No

Do your gums bleed? Yes No

How many times a do you: floss/week _____ brush/day? _____

Are your teeth sensitive to heat, cold or anything else? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Have you ever had any unfavorable dental experiences? Yes No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit ? _____

Here at *Gateway Family Dentistry* we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening

Veneers

Invisalign

Smile Makeover

Bonding

Sealants

Crown and Bridge

Dental Implants

Partials/Dentures

Night/Sport Guards

Electronic Toothbrush

Gateway Family Dentistry
Dr. Timothy Gailey
805 E Warner Rd., Ste 100
480-857-0745

Thank you, for choosing our office for your dental needs. We are committed to your treatment being successful and are always available to answer your questions or assist you in any way we can. The follow is a statement of our financial policy, which we require you to read and sign prior to any treatment.

- **All patients** must complete all forms prior to being seen by the doctor
- All treatment estimates are valid for 90 days
- **Full payment** is due at the time of service. We accept Visa, Master Card, Discover, American Express and debit cards
- A \$35 charge is incurred for returned checks
- Any balance left unpaid after 90 days will be turned over to small claims or collections and the patient will be dismissed from the practice

Regarding Insurance We accept assignment of insurance benefits. The balance is **YOUR RESPONSIBILITY** whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. Please be aware that the estimates that are given are just that. We do not guarantee insurance coverage or benefits. Please be aware that some or all of the services provided may not be a covered service under your insurance plan. **It is your responsibility to find out what is and is not covered.** You will be responsible for any balance not paid by your insurance company.

Minors The adult accompanying a minor to his/her appointment is responsible for payment at the time of service. Minors will not be treated if unaccompanied.

Missed Appointments Unless cancelled at least **24 hours in advance**, our policy is to charge for missed appointments at the rate of \$35 per half hour. This will help us cover a portion of our costs to make up for the time **especially reserved for you**. Please help us serve you better by keeping your scheduled appointments! Excessive missed or cancelled appointments will result in dismissal from the practice.

Thank you for understanding our Office Policy. Please feel free to let us know if you have any questions or concerns.

I have read, understand and agree to the above financial policy.

Patient or responsible party _____

Date _____

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you \$.25 for each page, \$25.00 per X-RAY and postage if you want the copies mailed to you. If you request an alternative format, we will charge you a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last 6 years but not before September 20, 2004. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions. But if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory

explanation as to how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances

Gateway Family Dentistry

Timothy Gailey, DMD
805 E Warner Rd., Ste 100
Chandler, AZ 85225
Phone: 480-857-0745
Fax 480-917-8955

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH
INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET
ACCESS TO THIS INFORMATION.

*PLEASE REVIEW IT CAREFULLY. THE PRIVACY
OF YOUR HEALTH INFORMATION IS IMPORTANT
TO US.*

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 9/20/2004 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve

the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have question or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use/disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may notify us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. Their contact information is provided for you at the end of this notice, as well.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

GATEWAY FAMILY DENTISTRY

Timothy Gailey, DMD
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Chandler, AZ 85225
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Fax 480-917-8955

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

USES AND DISCLOSURES

OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment

We may use and disclose your health information to a physician or other health care provider providing treatment to you.

Payment

We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations

We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credential activities.

Your Authorization

In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends

We must disclose your health information to you as described in the Patient Rights section I of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care but only if you agree that we may do so.

Persons Involved In Care

We may use or disclose health information to notify or in the assisting of notifying (including identifying or locating) a family member, your personal representative, or another person responsible for your care of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health Related Services

We will not use your health information for marketing communications without your written authorization.

Required By Law

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards or letters).

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Dr. Timothy Gailey
805 E. Warner Rd. #100
Chandler, AZ 85225

I understand that under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your **Notice of Privacy** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its notice of privacy from time to time and that I may contact this organization any time at the address above to obtain a current copy of the Notice of Privacy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name_____

Relationship to Patient_____

Signature:_____

Date:_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy, but was unable to do so as documented below:

Date

Initials

Reason