GS Dental

Great Service, Great Smiles

Patient Information

Name: _____ Preferred Name: _____
First MI Last

Date of Birth: _____ SSN: _____ Gender: ☐ Male ☐ Female

Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Contact preference: ☐ Text ☐ Call ☐ Email

In case of an emergency who may we contact?

Name: _____ Relationship: _____ Phone Number: _____

Responsible party (If different than patient)

Name: _____ Relationship_____ Date of Birth: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Insurance Information

Subscribers Name: _____ Relationship: _____
First MI Last

Date of Birth: _____ SSN: _____ Subscriber ID: _____

Employer: _____ Insurance Company: _____ Group#_____

Do you have additional (secondary) insurance?

Subscribers Name: _____ Relationship: _____
First MI Last

Date of Birth: _____ SSN: _____ Subscriber ID: _____

Employer: _____ Insurance Company: _____ Group#_____

Thank you for choosing GS Dental for all your dental care!

Whom may we thank for referring you? _____

Eaglesoft Medical History - (New Version)

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsilitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Venereal Disease
☐ Yellow Jaundice			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:

X Date:_____

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Financial Policy

Our Mission here at GS Dental is to help you afford the quality treatment you deserve.

We accept Visa, Mastercard, Discover, and American Express. We also accept CareCredit which offers differed interest for up to 24 months to those who qualify, or a longer term than 24 months with a set APR interest rate. Either of these plans allow you to make monthly payments. An application and credit check are required through CareCredit and generally will provide approval within a short period of time.

We work with most PPO dental insurances; however, Delta Dental is the only insurance company that we are a participating provider (In Network) with. Insurance carriers and policies vary, but we'll try our best to help you get the most out of your policy. As a courtesy to you, we will submit your dental claims for you, and answer any questions you have to the best of our knowledge. Please keep in mind that you are responsible for your total obligations should your insurance benefits result in less coverage than anticipated. We do require that you pay your estimated portion at the time of services. Any remaining balance due after 90 days of service becomes your responsibility, regardless of insurance coverage.

Our goal is to provide you with the best possible treatment and the time we reserve for you enables us to provide you with the care you need. Any appointment broken without 24 hours advance notice, excluding a medical emergency, will result in a cancellation charge of $50.00.

_____ _____

Patient or Responsible Party Signature Date

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Patient Consent

I understand that, under the Health Insurance Portability and 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 my treatment directly and indirectly.

Obtain payment from third party payers.

Conduct normal healthcare operations such as quality assessments and physical certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review the aforementioned document prior to signing this consent. I understand the organization has the right to change its policy from time to time and that I may contact this organization at any time at the address listed below to obtain a current copy.

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 healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent at any time in writing, except to the extent that you have taken action relying on this consent.

_____ _____

Patient Name Date

_____ _____

Signature Relationship to patient

GS Dental
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Albuquerque, NM 87109