Gordon Family Dental

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions, we'll be glad to help. (Please print.)

DAVID P. GORDON, DMD ♦ 323 EAST 100 NORTH, ♦ LEHI, UTAH 84043 ♦ 801-766-6344

♦PATIENT INFORMATION

Name _____ [ ]Dr. [ ]Mr. [ ]Mrs. [ ]Ms. [ ]Other: _____
First MI Last

Address _____ Occupation: _____ [ ] Male [ ] Female

City _____ State _____ Zip _____ Home # (___)_____

Employer _____ Work # (___)_____Ext____

Are you: [ ]Minor [ ]Married [ ]Single [ ]Divorced [ ]Widowed [ ]Separated Cell # (___)_____

DOB: ____/____/_____ SSN# _____-_____-_____ E-mail _____@_____

Spouse's Name _____
First MI Last (if different)

Spouse Occupation _____ Work phone # (___)_____Ext___

Is patient a full time student? [ ]No [ ]Yes: Name of School: _____

♦RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last

Address _____

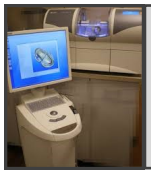
City _____ State _____ Zip _____

Home # (___)_____ Work # (___)_____Ext_____ Alt # (___)_____

DOB: _____/_____/_____

SSN# _____-_____-_____

Relationship: _____



Our practice is one of the most advanced CAD/CAM practices in the U.S. We use 3-D CEREC technology to produce ceramic restorations in a single visit.

♦YOUR PREFERENCES (check all that apply)

Do you prefer appointment reminders by: [ ]Email [ ]Phone [ ]Text

Do you prefer to receive calls from our office at: [ ]Home [ ]Work [ ]Cell

How do you wish to be addressed by our staff? _____

Whom may we thank for referring you? _____

♦INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____

DOB: _____/_____/_____ Subscriber's SSN# _____-_____-_____

Insurance Company _____ Policy # _____ Group # _____

DENTAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: _____/_____/_____ Subscriber's SSN# _____-_____-_____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ____/____/_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ]YES [ ]NO If yes, please complete the following:

Subscriber's Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: _____/_____/_____ Subscriber's SSN# _____-_____-_____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ____/____/_____

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♦MEDICAL HISTORY and CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of the entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

ALLERGIES (list reactions)

Acrylics	Y	N
Anaphalaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
What kind?_____		
Sulpha	Y	N
Other	Y	N

List other known allergies:

_____
_____
_____
_____
_____
_____

CARDIOVASCULAR

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

ENDOCRINE

Diabetes	Y	N
Circle one TYPE 1 TYPE 2		
Gout	Y	N
Hormonal Change	Y	N
Thyroid problems	Y	N
What kind?_____		

EYES, EARS, NOSE and THROAT

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus problems	Y	N
What kind?_____		
Tonsillectomy	Y	N
Tinnitus	Y	N

GASTROINTESTINAL

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

GENITOURINARY

Frequent Urination	Y	N
Kidney Disease	Y	N
Nocturia	Y	N

GENERAL

Current Weight: _____ lbs
Height: _____ ft _____ in

Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/Hip Replacement	Y	N
Liver Problems	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N

HEMATOLOGICAL

Bleeding problems	Y	N
Hepatitis	Y	N

ORAL

Bleeding Gums	Y	N
Dry Mouth	Y	N
Jaw problems (TMJ)?	Y	N
Clicking	Y	N
Pain	Y	N
Difficulty Swallowing	Y	N
Difficulty Chewing	Y	N
Orthodontics/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth Clenching	Y	N
Teeth Grinding	Y	N
Tooth Pain	Y	N
Wisdom Teeth Extracted	Y	N
Do you wear removable teeth?	Y	N
Do you take or need antibiotics before dental procedures?	Y	N

MUSCULOSKELETAL

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N

NEUROLOGICAL

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

PSYCHIATRIC

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating /Disorders	Y	N
Excessive Stress	Y	N
Memory problems	Y	N

RESPIRATORY

Asthma	Y	N
Bronchitis	Y	N
Breathing problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea(shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

SLEEP

Daytime Sleepiness	Y	N
Morning Headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N
How often? _____		
Has anyone told you that you snore?	Y	N

SOCIAL HISTORY

Do you smoke?	Y	N
_____packs/day		
Do you use smokeless tobacco?	Y	N
Do you consume alcoholic beverages?	Y	N
___Drinks per day/week/month		
Do you use recreational drugs?	Y	N

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♦MEDICAL HISTORY and CONSENT (continued)

List any medications you are taking:

	Medication	Dosage/Freq.	Prescriber	Reason
1.				
2.				
3.				
4.				
5.				
6.				

List any surgeries or hospitalizations you have had:

	Date (year)	Surgery	Surgeon	Reason
1.				
2.				
3.				
4.				
5.				
6.				

List and detail any medical condition or history not listed above:

_____

_____

_____

_____

Primary Physician's Name: _____ Physician's Phone #: (____)_____

Are you under the care of other physicians? If so, please list:

Physician	Phone Number	Reason

♦**GENERAL CONSENT TO DIAGNOSE AND TREAT:** The undersigned hereby authorizes David P. Gordon, DMD to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize David P. Gordon, DMD to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that David P. Gordon DMD, choose and employ such assistance as deemed necessary. I understand that the use of local anesthetic agents embodies certain risks and consent to their use as deemed appropriate by David P. Gordon, DMD. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in the medical health or status.

♦**FINANCIAL CONSENT:** I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered, not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1.5% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize David P. Gordon, DMD and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult):

Name of Patient: _____ _____ _____

Signature of Patient — Date

Consent (for a minor child):

Name of Parent/Guardian: _____ _____ _____

Signature of Parent/Guardian — Date

Notice of Privacy Practices (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____ _____

Signature of Patient or Parent/Guardian — Date

Gordon Family Dental

DAVID P. GORDON, DMD ♦ 323 EAST 100 NORTH, ♦ LEHI, UTAH 84043 ♦ 801-766-6344

Financial Policy

Thank you for choosing **Gordon Family Dental** as your Dental Healthcare Specialist. We are committed to giving you the highest quality treatment available and to your satisfaction. To help us meet these standards, we ask that you read and accept our financial policy as stated below. Please ask any questions you may have in regards to the policy before signing.

FULL PAYMENT IS DUE AT TIME OF SERVICE- We accept all major credit cards, debit cards, check cards, checks, and cash. We also accept Care Credit and Citi Health cards as payment plan options. Each returned check will be assessed a $25.00 fee.

REGARDING INSURANCE- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please understand that you may have to contact your insurance company if claims are denied. Since some of the procedures performed in our office are covered by medical insurance, we require both medical and dental insurance cards for your billing information. Our billing staff has undergone extensive training to maximize your insurance reimbursement, while reducing the time by which the insurance company will pay. The balance is your responsibility whether your insurance pays or not. We will not bill your insurance company if adequate information is not provided. All co-pays and deductibles are due at the time of treatment. _____
Initial

SECONDARY INSURANCE- Having more than one insurer DOES NOT necessarily mean that your services are covered at 100%. Secondary insurers will base their payments on what your primary carrier pays. We may bill your secondary carrier as a courtesy. If treatment is related to trauma, please understand that your auto or home owner's insurance policy may be requested by our office if applicable.

MINOR PATIENTS- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless consent forms have been signed and charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified.

DIVORCE DECREES- Please understand that our office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. We will be happy to print a receipt for a child's work so that you may submit it to another party for your reimbursement, but the financial responsibility for minors rests with the accompanying adult and is also due at the time of service.

MISSED APPOINTMENTS/CANCELLATION POLICY- Our office requires ***24 hours notice*** to reschedule any appointment. A fee of at least $30.00 will be charged to the guarantors account when the appointment is missed without sufficient notice or is canceled the same day. A $60.00 fee will be charged for any appointments that are 2 hours and longer. This has been implemented as a courtesy to our other patients who would be affected by missed appointments. *Please note that if you are more than 15 minutes late for your reserved appointment time, it may have to be rescheduled to another date and time.* _____
Initial

INTEREST- We reserve the right to charge interest in the amount of 1.5% per month (18% annually) on all unpaid balances left outstanding after 30 days as provided by state law.

I have read the entire Financial Policy and have had sufficient time to study and understand it, or obtain legal counsel if I so desire. I agree to be bound by all of the foregoing terms and conditions. In the event that the terms of this agreement are not met, I agree to pay the principal amount, plus all attorney's fees, court costs, and all costs of collection, including 50% of the principal amount assigned to any collection agency.

Consent (adult):

Name of Patient: _____ _____ _____
Signature of Patient — Date

Consent (for a minor child):

Name of Parent/Guardian: _____ _____ _____
Signature of Parent/Guardian — Date

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