2336 S. Main St
Maryville, MO 64468
660-582-4655

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Welcome to Gardner Family Dentistry

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Gender: ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth: _____ **SS#:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____
Home Work Ext Mobile

Address: _____ _____ _____ _____
Street City State Zip Code

Please enter Employer and Occupation: _____

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

In an emergency who should be notified? Please enter name and phone number below. _____

_____

Dental Information

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Reasons for today's visit? _____

Date of most recent dental exam and dental x-rays: _____

Was there anything about your last dentist that you didn't like? _____

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

_____

Please check all that apply:

☐ You experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Have you experienced popping and/or clicking of your jaw joint?
☐ You clench or grind your teeth
☐ You wear or have worn a bite appliance
☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Experienced gum recession
☐ If any of the checked boxed need further explanation, please describe below:

Medical History

Indicate which of the following conditions you have or have had. By checking the box, it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Pre-med
- ☐ Blood Thinner
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Allergy
- ☐ HIV
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Asthma
- ☐ Artificial Joints
- ☐ Acid Reflux
- ☐ Tobacco/Alcohol Use
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant or Nursing

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

If you take antibiotic premedication such as Amoxicillin, Clindamycin, or Penicillin for your dental visits, please indicate below: _____

Are you allergic to any of the following medications? Please check all that apply:

☐ Amoxicillin ☐ Clindamycin ☐ Penicillin

Please list all allergies: _____

_____

Name of your pharmacy and phone number: _____

Describe any current medical treatment, impending surgery, or other treatment that my possibly affect your dental treatment. _____

_____

Have you ever taken or are you taking Bisphosphonates (Bone strengthening medication)? ☐ Yes ☐ No

List all medications or provide a medication list to the office staff (prescription and non-prescription) including regular doses of aspirin: _____

_____

_____

Primary Dental Insurance:

If you have Dental Insurance, please present your card to the Front Desk.

Name of Insured: _____ _____ _____
Last First MI

Insured's Date of Birth: _____ **SSN#:** _____ **Group#:** _____

Insured's Employer Name: _____

Insurance Authorization:

☐ *By checking this box, I authorize my insurance company to pay the dentist all insurance benefits rendered.*
I authorize the use of this electronic signature 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.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs associated with collections.

I grant my permission to you or your assignee, to contact me to discuss this statement or my treatment.

☐ *By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration form.*

Consent for Software Communications:

This grants my permission for the dental practice to securely upload and store my patient information via the dental office's electronic software.

I understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gather, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the software on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SOFTWARE OR THE SERVICES.

☐ *I have read the information above regarding the secured uploading of patient information to the software for the dental practice, and grant the dental practice permission to securely upload my patient information to the software. This will serve as my electronic signature.*

By signing below, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly and accurate to the best of my knowledge. There are no other medical conditions or medications/allergies that have not been listed. I am aware that it is my responsibility to notify the practice of any future changes.

X Signature: _____ Date: _____