Patient Name ____ Male Female

Legal Guardian Name (if patient is under 18) ____

Date of Birth ____________ Social Security # ______________ Married Single

Address ____ Apt # ________________

City ____________________________ State ___________ Zip __________________

Telephone Numbers: Home _______________ Work ___________ Cell

Email Address ________________________ Employer ___________________________

Nearest relative not living with you:

Name _____________________ Address _________________________________

City/State/Zip __________________________ Phone # ___________________________

How did you hear about our office? Check all that apply:

Friend/Relative (name) ____________________________

Phone book _______Mailer _______ Website _______ Drive By _______

Please tell us what services you are interested in: (circle all that apply)

Replacing silver fillings | Having a whiter smile
Oral Conscious Sedation | Tooth replacement (implants/bridge)
Smile Makeover | Straighter teeth

Please tell us of any other specific dental concerns you may have:

____

CONSENT TO PROCEED: I authorize Gateway Dental Doctors or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or any minor or other individual for which I have responsibility, including arrangements and/or administration of any sedative, restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include numbness, bruising and muscle soreness. I do voluntarily assume any and all risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired result, 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. Further, I understand that I am entering into a contractual relationship with the Gateway Dental Doctors for professional care. I further understand that meritless and frivolous claims for medical/dental malpractice have an adverse effect upon the cost and availability of healthcare, and may result in the irreparable harm to a healthcare provider. As additional consideration for professional care provided to me, I, the patient/guardian and or my representative agree not to advance, directly or indirectly, any false, meritless and/or frivolous claim(s) of medical/dental malpractice against Gateway Dental Doctors. Furthermore, should a meritorious medical/dental malpractice case or case of action be initiated or pursued, I and/or my representative agree to use expert witness(es) who practice primarily in the same specialty as Doctor. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this, Gateway Dental Doctors agree to the same stipulations.

____ ____________________

Signature of Patient, legal guardian or agent Date

FINANCIAL INFORMATION AND POLICIES

Person responsible for this account ____
Marital status: Married Single
Address ____
Drivers License Number _________________________Phone Number__________________

Is patient covered by dental insurance? Yes or No

Insurance Company Name ____
Address ________________________________City/State/Zip _________________________
Telephone # ____________________________________
Whose name is the policy under? _____________________Group # ____________________
Date of Birth______________________ Social Security # __________________________
Employer Name ____________________________ Employer Phone # ________________

Is patient covered by secondary insurance? Yes or No
Insurance Company Name____
Address _________________________________ City/State/Zip ______________________
Telephone # ____
Whose name is the policy under? _________________ Group # ______________________
Date of Birth ____________________ Social Security # ______________________________
Employer Name ____________________________ Employer Phone # ________________

DENTAL INSURANCE is a contract between a patient/guardian and the insurance company and in no way absolves the patient/guardian of full responsibility for the charges incurred. Estimates of insurance payment made by this office are considered a guideline only. We can make no guarantee of the insurance payment(s) estimated. We are pleased to help process insurance forms, help maximize your insurance benefits and are glad to help answer any questions you may have about your treatment or treatment estimates. I hereby authorize payment directly to Gateway Dental of the group insurance benefits otherwise payable to me.

SCHEDULED APPOINTMENTS: The time scheduled for your visit is set aside especially for you. We look forward to making your visit pleasant, comfortable and productive. In the unlikely event you are unable to make your appointment we ask that you give us two business days notice so that we may give this time to other patients needing treatment. There will be a $55 charge for appointment(s) missed or broken without two business days notice.
FINANCE CHARGES: A monthly charge of 1.5% (18% annually) will be added to all account balances not paid within 60 days of services. A late fee of $10/month will be assessed to all past due accounts.
I have read, understand and agree to the above policies. In the event of default, I agree to pay all costs of collection as well as court costs and reasonable attorney's fees in the event legal action is taken.

Patient Signature ____ Date ________________

Witness Signature
____ Date ________________

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WWW.DENTISTRYOFOHIO.COM

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

The Dentists at Gateway Dental and the patient listed below agree to maintain Privacy of the patient as outlined in the HIPAA form. The Dentists take pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law. Federal and State privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, HIPAA forbids dentists from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to the patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Gateway Dental believes this is improper and may not be in the patients' best interest. Accordingly, the Dentists agree not to provide any list to an outside company for marketing anything other than our office or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly. Regardless of legal privacy loopholes, Gateway Dental will never attempt to leverage its relationship with patient by seeking patients' consent for marketing products for other companies. In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Gateway Dental or the dentists; expertise and/or treatment – the sole exceptions being communication to a confidential dental-peer review body: to another healthcare provider: to a licensed attorney: to a governmental agency: in the context of a legal proceeding; or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym or anonymously. If Patient does prepare commentary for publication about Gateway Dental and/or our dentists or employees, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Gateway Dental for any written, pictorial, and/or electronic commentary. This assignment is in further consideration for additional privacy protections provided by Gateway Dental. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Gateway Dental has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon Gateway Dental or its dentists. Patient will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage the practice. Our Dentists feel strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Dentists and Patients will work to prevent the publishing or airing of commentary about the other party from being accessed via internet, blogs or other electronic, print or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Dentists last date of service to the patient or (b) three years beyond any termination of the dentist-patient relationship. As a matter of office policy, Dentists are requiring all patients in the practice to sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all patients.
Patient and Dentists acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, patient and Dentists agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation. Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

Patient or Guardian Signature ____ date ____________

Witness Signature ____ date __________

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GATEWAY
DENTAL CARE

MEDICAL HISTORY

Physician's Name: ______________________

Phone #: ( ) ______________________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain: ______________________

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription/OTC drugs? ☐ Yes ☐ No

Please list each one: ______________________

Have you ever taken Phen-Fen? (or Redux) ☐ Yes ☐ No
If so, when? ______________________

Have you ever taken Fosamax? ☐ Yes ☐ No

For Women:

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # ________

Are you nursing? ☐ Yes ☐ No

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

Y	N	Abnormal bleeding/hemophilia	Y	N	Herpes/Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol/Drug Abuse	Y	N	HIV +
Y	N	Anemia	Y	N	Hospitalized
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic/Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack/Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical conditions that you have ever had:

____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Codeine
Y	N	Dental Anesthetics	Y	N	Erythromycin
Y	N	Jewelry/Metals	Y	N	Latex
Y	N	Penicillin	Y	N	Tetracycline
Y	N	Other			

Please list any other drugs/materials that you are allergic to:

____

DENTAL HISTORY

Why have you come to the dentist today? ______________________

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

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

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Med ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

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

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change?

____

I understand that the information 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

____

Signature **Date**

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein.

Initials: ______________________ **Date:** ______________________

Doctor's Comments:

____

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