GLADSTONE FAMILY DENTAL GROUP, PC
GREGORY W. DALE, D.D.S.
DAVID S. PLATT, D.D.S.

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____
Soc. Sec. # _____
Home Phone _____

Name _____ Birthdate _____ Cell # _____
Email _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS# _____
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ Discover ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

Patient Name _____

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐

9. Women Only:	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
If yes, due date _____		
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

10. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
AIDS or HIV Infection	☐	☐	Frequently Tired	☐	☐	Low Blood Pressure	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐
Angina	☐	☐	Heart Attack	☐	☐	Radiation Therapy	☐	☐
Arthritis	☐	☐	Heart Disease	☐	☐	Recent Weight Loss	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Respiratory Problems	☐	☐
Cancer	☐	☐	Heart Trouble	☐	☐	Rheumatic Fever	☐	☐
Cardiac Pacemaker	☐	☐	Hay Fever / Allergies	☐	☐	Sexually Transmitted Disease	☐	☐
Chest Pains	☐	☐	Hepatitis / Jaundice	☐	☐	Stomach Troubles / Ulcers	☐	☐
Diabetes	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Easily Winded	☐	☐	Joint Replacement or Implant	☐	☐	Swollen Ankles	☐	☐
Emphysema	☐	☐	Kidney Diseases	☐	☐	Tuberculosis	☐	☐
Epilepsy / Convulsions	☐	☐	Leukemia	☐	☐	Thyroid Problem	☐	☐
Fainting / Seizures	☐	☐	Liver Disease	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Have you ever had any prolonged bleeding following extractions?	☐	☐
11. Have you had any orthodontic treatment?	☐	☐
12. Do you snore?	☐	☐
13. Do you have sleep Apnea?	☐	☐
14. Has CPAP been recommended for you?	☐	☐
15. Are you currently using CPAP?	☐	☐
16. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
17. Do you like your smile?	☐	☐
18. Are you interested in whitening your teeth?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date: _____

Signature of patient (or parent if minor)

Doctor's Comments _____

_____

_____ Signature _____ Date _____

Gladstone Family Dental Group Office Policy

In an effort to be more efficient and keep rising costs under control, we are requiring patients to **pay all** estimated co-pays and deductibles at the time of service. Your insurance coverage is a contract between you and your insurance company. Insurance will continue to be filed as a courtesy to our patients and we will wait 60 days for payment from your insurance company. We do not accept direct payment for benefits from secondary insurance companies, therefore patients will be responsible for estimated balances or co-payments at the time of services other than their estimated primary insurance payment. You always remain responsible for your account.

We are now requiring **48 hours** notice for any schedule changes or cancellation. If an appointment is not cancelled prior to **48 hours** or you fail to show for the appointment, a fee of $50.00 for each appointment hour could be charged to your account and must be paid prior to scheduling future appointments. After 3 consecutive broken appointments you could be dismissed from our practice.

Patients with outstanding balances, including insurance pending balances, need to contact the office immediately to set-up financial arrangements. Our office offers several different options and will be happy to work with each patient to find the most accommodating arrangement for both parties.

We **strongly** recommend that each patient schedule any future appointments, whether it is your regular recall appointment, exam or more extensive treatment, so that we may better serve our patients.

We appreciate your understanding and cooperation in regards to these changes.

Thank you,

Gregory W. Dale, DDS
David S. Platt, DDS

PATIENTS' SIGNATURE DATE

Gladstone Family Dental Group

Gregory W. Dale, DDS and David S. Platt, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____ SSN: _____

I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Also, by signing this consent form, acknowledge the receipt of a copy of Gladstone Family Dental Group's Notice of Privacy Practice brochure.

Signature: _____ Date: _____

*If this consent is signed by a personal representative on behalf of the patient complete the following:

Name: _____ Relationship: _____

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 April 27, 2009, 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.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

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

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

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare 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 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 healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (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 healthcare. 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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 $0.75 for each page, $20.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge 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, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

Restriction: 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 satisfactory explanation 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions 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 or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to 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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
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.

HIPPA Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____

Birthdate: _____

Signature: _____

Date: _____