Gateway Dental William F. Swann, DDS.

Patient Information

Patient Name: _____

Date:_____ Last First M I Preferred name

Male Female Married Single Child Other_____ Birth

Date:_____ Social Security #:_____

Address:

_____ Street

Apartment #

_____ City

State Zip Code

Phone (Home): _____ (Work): _____ Ext:_____ Best time to

call:_____ Cell Phone:_____ Email

Address:_____

Health Information

Date of Last Dental Visit: _____ *Reason for this visit*:_____

Have you ever had any of the following? Please check those that apply:

AIDS/HIV
Allergies
_____
_____ Anemia
Arthritis
Artificial Joints
Asthma
Blood Disease
Cancer
Diabetes
Dizziness
Epilepsy
Excessive

Bleeding Fainting
Glaucoma
Growths
Hay Fever
Head Injuries
Heart Disease
Heart Murmur
Hepatitis
High Blood
Pressure Jaundice
Kidney Disease
Liver Disease
Mental Disorders

Nervous
Disorders
Pacemaker
Pregnancy
Due date:_____
Radiation Treatment
Respiratory Problems
Rheumatic Fever
Rheumatism
Sinus Problems
Stomach Problems
Stroke
Tuberculosis

Tumors
Ulcers
Venereal Disease
Codeine Allergy
Penicillin Allergy
OTHER:
_____

_ Mitro Valve

Prolaspe

Please list any medications you are currently taking _____

• Have you ever had any complications following dental treatment? Yes No
If yes, please explain:_____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No If yes, please explain:_____

• Are you now under the care of a physician? Yes No
If yes, please explain:_____ •

Name of Physician: _____ Phone:_____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other_____

Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name:

Male Female Married Single Child Other

Social Security #: _____ Birth Date:

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call:

Address:

Street Apartment # City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: Occupation:

Address:

Street City State Zip Code

If you are a student, name of school/college:

_____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:

Insured's Address:

Street City State Zip Code Insured's Employer Name:

Address:

Street City State Zip Code Patient's relationship to insured: Self Spouse Child Other_____

Insurance Plan Name and Address:

Secondary

Name of Insured: _____ Is insured a patient? Yes No Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:

Insured's Address:

~~Street City State Zip Code~~ Insured's Employer Name:

Address:

Street City State Zip Code Patient's relationship to insured: Self Spouse Child Other_____

Insurance Plan Name and Address:

Assignment of Insurance Benefits and Release of Information

I, the undersigned, certify that I (or my dependants) have dental insurance coverage with_____ and assign directly to Gateway Dental Dr. William Swann DDS all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance whether manual or electronic.

Responsible Party Signature _____ *Date*_____

Dental Health Information

1. Are you having any discomfort at this time? Explain: _____ 2. Have you ever had any serious complications associated with previous dental procedures? Explain: _____ _____ 3. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____ 4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____ If so, when? _____ 5. How often do you brush? _____ Brush is: Soft _____ Medium _____ Hard

6. Do you have, or have you ever had any of the following? Please check those that apply:

MOUTH

- ❑ Bleeding, sore gums
- ❑ Unpleasant taste/bad breath
- ❑ Burning tongue/lips
- ❑ Frequent blisters, lips or mouth
- ❑ Swelling/lumps in mouth
- ❑ Braces
- ❑ Biting of cheeks/lips
- ❑ Clicking/popping jaw
- ❑ Difficulty opening or closing jaw

TEETH

- ❑ Loose teeth
- ❑ Sensitivity to heat
- ❑ Sensitivity to cold
- ❑ Sensitivity to sweets ❑ Sensitivity to biting ❑ Food impaction
- ❑ Clenching/grinding … If so, when? _____ ❑ Shifting in bite
- ❑ Change in bite

7. Are you happy with your smile and the appearance of your teeth in general (Color, Shape, Spaces)? _____ If "no", why not? _____ _____

8. Do you smoke? € Yes € No Do you use any other tobacco product? _____ Frequency of use: _____

For Completion by Dentist Only

Comments on patient interview concerning medical history:

_____
_____
_____

Significant findings from questionnaire or oral interview:

_____
_____
_____Dental management considerations:

_____
_____

_____

_____ _____ (Date)
(Signature of Dentist)

MEDICAL HISTORY UPDATE:
Date Comments Signature _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____

Our Office and Financial Policies

Thank you for choosing us as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions, please feel free to ask any staff member for more information.

APPOINTMENTS

Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care, and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you must change an appointment, a ***24-hour notice*** is expected. A fee may be applied for appointments missed without notice. Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.

INSURANCE

As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, ***we do require you to pay your deductible and/or "estimated patient portion" at the time of service***. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. If you have dental insurance, you must provide us with your dental insurance card and a claim form if needed. We must be able to verify coverage before we can accept assignment of benefits. Please note that dental insurance plans are different from your medical insurance. Each plan has different yearly deductibles and benefits. Most insurance plans will pay, at most, 80% of Basic procedures and 50% of Major procedures. When possible, we will submit a dental pre-estimate to your insurance company for review. This will allow you to know the exact amount that the insurance company will pay. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that I am responsible for reading and understanding my dental insurance benefits._____

initial

USUAL AND CUSTOMARY RATES

Please be aware that some of our services may be "non-covered", subject to an insurance company's arbitrary determination of usual and customary rates, or have time limitations imposed by the insurance company. Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive. ***You are responsible for any balance left unpaid by your insurance company***. The adult accompanying a minor is responsible for full payment.

PAYMENT OPTIONS AND ACCOUNT INFORMATION

In order to maintain our fees at a reasonable level, we do not send monthly statements. If a balance is over 30 days, a billing fee will be charged at the rate of 1.5% per month of the total balance, or $7.00, whichever is greater. In the event we receive a returned check for insufficient funds or a closed account, there will be a $35.00 fee charged to your account. Collection fees of 35% of the account balance will be added to any balance turned over for collection purposes.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA and

MASTERCARD Thank you for understanding our guidelines. Please let us know if you have any questions or

concerns.

I have read, understand, and agree to the above office and financial policies.

X _____ _____

Signature of patient or responsible party Date