

Welcome

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)

GS Dental LLC, 7910 Wyoming Blvd. Suite A, Albuquerque, NM 87109 505-883-5835

PATIENT INFORMATION

Name _____ Dr. Mr. Mrs. Ms. Rev. Other: _____
 First _____ MI _____ Last _____
 Address _____ Occupation: _____ Male Female
 City _____ State _____ Zip _____ Hm# (____) _____
 Employer _____ Wk# (____) _____ 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 _____
 Hm# (____) _____
 Wk# (____) _____
 DOB: ____ / ____ / ____
 SSN# _____
 Relationship: _____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____
 DOB: ____ / ____ / ____ Subscriber's SSN# _____

Insurance Company _____ Policy # _____ Group # _____

DENTAL INSURANCE:

Insured Name _____ Relationship to patient: _____
 Address _____ City _____ State _____ Zip _____
 DOB: ____ / ____ / ____ SSN# _____ Employer: _____
 Insurance Company _____ Group # _____ Eff. Date: ____ / ____ / ____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? Yes No If yes, please complete the following:

Insured Name _____ Relationship to patient: _____
 Address _____ City _____ State _____ Zip _____
 DOB: ____ / ____ / ____ SSN# _____ Employer: _____
 Insurance Company _____ Group # _____ Eff. Date: ____ / ____ / ____

YOUR PREFERENCES

Do you prefer appointment reminders by:
 Email Phone Text

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

Whom may we thank for referring you?

How do you wish to be addressed by our staff?



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

CONFIDENTIAL

"Our practice is dedicated to helping you have good oral health for a lifetime."

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, can affect your dental health.

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No	
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No	
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>

Women: Are you...

 Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin
 Metal Latex

Codeine Acrylic
 Sulfa Drugs Local Anesthetics

Other?

If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easy Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sidite Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Painting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easy	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain In Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?

 Yes NoIf yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

GS Dental ~ Financial Policy

Our mission here at GS Dental is to help you afford the quality treatment that you deserve. We accept Visa, Mastercard, Discover and American Express. We also offer zero interest financing for up to 24 months to those who qualify, or longer terms with small interest charges. These plans allow you to make monthly payments. Application needs to made prior to your appointment, and we usually receive approval in a short period of time.

We work with most dental insurers. Carriers vary, but we'll try to help you get the most out of your particular policy. As a courtesy to you, we will submit your claim forms for you, and answer any questions we can. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. We do require that you pay the portion that your insurance policy doesn't cover at the time of service.

Any remaining balance after 60 days becomes your responsibility, regardless of insurance coverage. At that point, you will be charged 1.50% per month on the remaining balance until it is paid in full.

Our goal is to provide you with the best possible treatment and the time we reserve for you enables us to provide you with the care you need. Any appointment broken without a 24 hour advance notice, excluding a medical emergency, will result in a cancellation charge of \$50.00.

Date_____

Signature