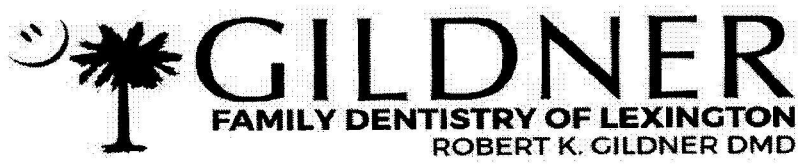

Patient Information

First Name_____ Last Name_____ M/I_____

Address_____

City_____ State_____ Zip code_____

Home Phone_____ Cell Phone _____

Sex: ( ) Male ( ) Female Marital Status ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

Date of Birth _____ Age _____

SS Number _____ Drivers License # _____ State_____

Email _____

Primary Insurance Info:

Name of Insured (First)_____(Last)_____

Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured SS Number _____ Insured Date pf Birth _____

Employer _____ Insurance Co _____

Address _____ Address _____

City State Zip _____ City State Zip _____

Secondary Insurance Info

Name of Insured (First)_____(Last)_____

Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured SS Number _____ Date pf Birth _____

Employer _____ Insurance Co _____

Address _____ Address _____

City State Zip _____ City State Zip _____

Gildner Family Dentistry Patient Medical History

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? If, yes _____

Have you been hospitalized or had a major surgery? _____

Have you ever had a serious head or neck injury? _____

Are you taking any medications, pills, or drugs? _____

Do you take or have you taken Phen-Fen or Redux? _____

Have you ever taken Fosamax, Boniva, Actonel, or bisphosphonate medication? _____

Are you on a special diet? _____

Do you use tobacco? _____

Do you use controlled substances? _____

Women Only...Are you...

Pregnant/Trying to get pregnant? _____

Nursing? _____

Taking oral contraceptives? _____

Are you allergic to any of the following?

Aspirin _____

Metal _____

Penicillin _____

Latex _____

Codeine _____

Sulfa Drugs _____

Acrylic _____

Local Anesthetics _____

Others _____

Do you have or have had any of the following? **Circle all that apply.**

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation
Alzheimer's Disease	Diabetes	Hepatitis A	Renal Dialysis
Anaphylaxis	Drug Addiction	Hepatitis B or C	Rheumatic Fever
Anemia	Easily Winded	Herpes	Rheumatism
Angina	Emphysema	High Blood Pressure	Scarlet Fever
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Shingles
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Sickle Cell Disease
Artificial Joint	Excessive Thirst	Hypoglycemia	Sinus Trouble
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Spina Bifida
Blood Disease	Frequent Cough	Kidney Problems	Stomach/Intestinal Disease
Blood Transfusion	Frequent Diarrhea	Leukemia	Stroke
Breathing Problems	Frequent Headaches	Liver Disease	Swelling of Limbs
Bruise Easily	Genital Herpes	Low Blood Pressure	Thyroid Disease
Cancer	Glaucoma	Lung Disease	Tonsilitis
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tuberculosis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tumors or Growths
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Ulcers
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Venereal Disease
Convulsions	Heart Trouble/Disease	Psychiatric Care	Yellow Jaundice

Have you ever had any serious illness that is not listed above? _____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian

_____

HIPPA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES AND CONSENTLIMITED AUTHORIZATION & RELEASE FORM. YOU MAY REFUSE TO SIGN THIS ACKNOWLEGEMENT & AUTHORIZATION. IN REFUSING WE MAY NOT BE ALLOWED TO FILE YOUR INSURANCE CLAIM.

Date _____ The undersigned acknowledges receipt of a copy of the currently effective notice of privacy practices for the healthcare facility. A copy of this signed dated document shall be as effective as the original. My signature will also serve as document release should I request treatment or radiographs be sent to another attending doctor / facility in the future.

_____ _____

Name of patient (please print) Signature of patient, parent/guardian

_____ _____

Legal Representative / guardian Relationship of legal representative/guardian

Your comments regarding acknowledgement or consent _____

How do you want to be addressed when summoned from the reception area:

First Name Sir Name Other

Please list any other parties who can have access to your health information. This includes spouse, step parents, grandparents and any caretakers who have access to this patient records.

Name _____ Relationship_____

Name _____ Relationship _____

I authorize contact from this office to confirm appointments, treatments, billing, information about my health or any new health information. On behalf of this healthcare facility via

Cell phone confirmation	Home phone confirmation	Text Message to my cell phone
Work phone confirmation	Email confirmation	Any of the above

Dental Insurance Responsibility Acknowledgment

Name: _____
Date of Birth: _____
Date: _____

Dental Office Information
Gildner Family Dentistry of Lexington
602 East Main Street Suite E Lexington SC 29072
(803) 957-2440

Acknowledgment of Insurance Responsibilities

I, the undersigned patient, understand and agree to the following:

1. **Insurance Claim Responsibility:** I acknowledge that my dental insurance company is solely responsible for the approval or denial of any claims submitted on my behalf. The dental office cannot guarantee that any treatment will be covered by my insurance.

2. **Estimated Fees:** I understand that any amounts collected by the dental office prior to treatment are based on estimated information provided by my dental insurance company. These estimates are not a guarantee of payment.

3. **Treatment Plan Estimates:** I acknowledge that all fees and portions of dental treatment plans provided by the dental office are estimates. The actual amounts owed may vary based on the final determination made by my insurance company.

4. **Official Determination:** I understand that the Explanation of Benefits (EOB) provided by my dental insurance company is the official determination of coverage and payment responsibility. It is my responsibility to review this document and understand my financial obligations. It is my responsibility to understand the frequencies and limitations on my dental insurance plan.

5. **Payment Responsibility:** I agree to pay any remaining balance that is not covered by my insurance in a timely manner, as outlined in the dental office's payment policies, unless my personal dental insurance plan dictates differently. I understand that any payments collected by the dental office prior to my dental insurance company providing an EOB are an estimation and may not be my full responsibility.

By signing this document, I confirm that I have read and understood the above statements regarding my insurance coverage and payment responsibilities.
Signature of Acknowledgment
Patient Signature: _____
Date: _____