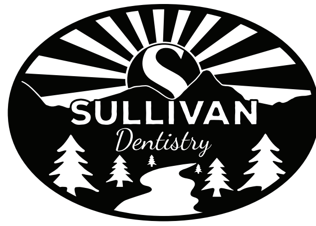
Welcome



Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

PATIENT INFORMATION

Name: ______ Birthdate ______ S.S.# ______

Address ______ City ______ State ____ Zip ______

Sex ☐ M ☐ F Home Phone ______ Cell Phone ______ E-mail ______

Employer / School ______ Employer / School Phone ______

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 ______ Relation to Patient ______

Address ______ Home Phone ______

Employer ______ Work Phone ______

Birthdate ______ Cell Phone ______

S.S.# ______ Email ______

Currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured ______ Relation to Patient ______

Birthdate ______ S.S.# ______ Date Employed ______

Employer ______ Work Phone ______

Employer City ______ ST ______ Zip ______

Insurance Company ______ Group # ______ Subscriber ID# ______

Address ______ City ______ ST ______ Zip ______

ADDITIONAL INSURANCE

Name of Insured ______ Relation to Patient ______

Birthdate ______ S.S.# ______ Date Employed ______

Employer ______ Work Phone ______

Employer City ______ ST ______ Zip ______

Insurance Company ______ Group # ______ Subscriber ID# ______

Address ______ City ______ ST ______ Zip ______

DENTAL HISTORY

Reason for today's visit ______ Date of last dental care ______

Previous Dentist ______ Date of last dental X-rays ______

Check (✓) if you have had problems with any of the following:

☐ Bad breath ☐ Food collection between teeth ☐ Sensitivity to hot ☐ Sensitivity to cold
☐ Bleeding gums ☐ Loose teeth or broken fillings ☐ Sensitivity to sweets ☐ Sores or growths in your mouth
☐ Clicking or popping jaw ☐ Grinding teeth ☐ Periodontal treatment ☐ Sensitivity when biting

How often do you floss? ______ How often do you brush? ______

OVER - CONTINUED ON BACK

MEDICAL HISTORY

Are you under a physician's care now? ☐ Yes ☐ No

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

Did you ever take the drug Phen-Fen or Redux? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Have you been hospitalized or had a major operation? ☐ Yes ☐ No

Please list any medications you are taking.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications for osteoporosis? ☐ Yes ☐ No

Are you alergic to:

Asprin	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Acrylic	☐ Yes	☐ No
Metal	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Local Anesthetic	☐ Yes	☐ No

Women are you:

Pregnant/trying to get pregnant?	☐ Yes	☐ No
Taking oral contraceptives?	☐ Yes	☐ No
Nursing?	☐ Yes	☐ No

Please list any other allergies: ______________________________

____

____

____

Check (✓) if you have had or have any of the following:

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

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with (Name of Insurance Company(ies) ______________________________ and assign directly to Dr. ______________________________ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient or Responsible Party ______________________________ Date ______________________________

Print name of Patient or Responsible Party ______________________________ Relationship to Patient ______________________________

Payment is due in full at time of treatment unless prior arrangements have been approved.

GABRIEL PAUL SULLIVAN, DDS, PLC

Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of GABRIEL PAUL SULLIVAN, DDS, PLC. I hereby authorize, as indicated by my signature below, GABRIEL PAUL SULLIVAN, DDS, PLC to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

______________________	______________________
Print Name	Address
______________________	______________________
Signature	Date

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number ______________________
- ☐ You may contact me on my mobile telephone number ______________________
- ☐ You may contact me on my work telephone number ______________________
- ☐ You may send me an email at: ______________________
- ☐ Other: ______________________

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

(circle):

1. ______________ Relationship: ____________ Date _/_/__ added / removed
2. ______________ Relationship: ____________ Date _/_/__ added / removed
3. ______________ Relationship: ____________ Date _/_/__ added / removed
4. ______________ Relationship: ____________ Date _/_/__ added / removed

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify) ______________________

Staff Person Initials ________

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PATIENT CONSENT

Clinical

1. I authorize GABRIEL PAUL SULLIVAN, DDS, PLC, to perform all recommended treatment. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

2. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

3. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

4. A $50 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hour notice of cancellation is required.

Insurance

5. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

6. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.
Patient's Name: ______________________________ Date: ________________
Patient's Address: ____
If patient is a child, please provide the parental or legal guardian's consent:
Signature: ____________________ Relationship: ____________________ Date: ________

NOTE (MINORS): The parent or legal guardian must complete this form for a minor, provide consent for dental treatment and accompany the child during each dental visit. If the parent or guardian consented to treatment in advance, an authorized individual named on Page 1 may bring the child. Treatment will not be provided for unattended children.

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