Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Mailing Address _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Pharmacy Name _____ Phone _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Mailing Address _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

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

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Do you wish your teeth were straighter? ❑ Y ❑ N

Do you wish your teeth were whiter? ❑ Y ❑ N

Are you unhappy with any fillings, crowns or bridges? ❑ Y ❑ N

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Do you smoke or use other tobacco/smokeless products? ❑ Y ❑ N Please circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other _____

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

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

GOLDEN TRIANGLE
dentistry

APPOINTMENTS:
Your appointment is prearranged. Your appointment time is reserved exclusively for you. Therefore, we request that you provide Forty-eight (48) hours notice for cancellations and reschedules. *Cancellations or reschedules with less then forty-eight (48) hours notice as well as a frequent cancellations/reschedules with notice, and "NO SHOWS" will be subject to a $25.00 or up fee according to treatment schedules, which is due at the next visit. Please be aware that dental insurance companies will NOT cover any such fee~~ prompt payment is the responsibility of the patient *MONDAY appointments require 72 hours notice (by 12pm/noon on the Thursday before.)*

TREATMENT FOR MINORS:
Moms/Dads/Relatives/Guardians must remain present throughout the child's entire appointment. (If a working cell phone number is given, parents can leave the office). Children who are under 18 and brought to their appointment by Siblings/Relatives/Guardians please send a dated and signed consent note with a current phone number where the parent/guardian can be contacted for the date and time of the appointment. If sending payment with the patient please include the check writer's driver's license number at the top of the check. Please limit number of friends/family who accompany Parent/Guardian to child's appointment. We ask this for everyone's comfort.

PAYMENT:
Our office policy is that payment is due at the time services are rendered. By not having to bill we can keep our costs down and pass savings on to our patients.

INSURANCE:
Private and group insurance plans: The Insurance Department at Golden Triangle Dentistry will bill your insurance company as a courtesy to you once you have provided a copy of your current insurance card. This service is provided as a courtesy. You are required to pay your co-payment and deductible at the time of service. At all times we ask that YOU contact your insurance company directly to ensure that your claim(s) are being handled properly and are paid in a timely manner. If your insurance company fails to pay the claim for any reason (i.e. no eligibility, limitation of coverage, request of additional information from insured, residual balances, etc…) you are ultimately responsible for the total remaining balance which is to be paid within 30 days.

PERSONAL HEALTH INFORMATION AND PRIVACY (HIPAA):
I understand that this office will not use my personal health information, including social security number, date of birth, phone number, for any other purpose other than billing of dental treatment. Furthermore, I understand that a copy of these doctors "NOTICE OF PRIVACY PRACTICES" has been made available to me. I also understand that I have important rights relating to inspecting and copying my medical information that the doctor maintains, amending or correcting that information, and obtaining an accounting of the doctor's disclosures. I also have the right to request this doctor to communicate with me should a request for my personal health information be made from anyone other than me. I give this office my written consent to disclose my personal health information for purposes of health care, the payment for or reimbursement of care provided to me and the related administrative activities supporting my treatment.

DENTAL MATERIALS FACT SHEET:
I acknowledge that I have received from the dentist a copy of the Dental Materials Fact Sheet dated

MAY 2004

Signature of Patient/Name_____Date_____

Signature of Parent/Guardian_____Date_____

Dear Patient,

Please be advised that we do have a 48 hour reschedule/cancellation policy.

If 48 hours is not given, you **WILL be charged anywhere from $25-100** depending on the broken appointment.

As of May 30, 2022, our office will be closed on Fridays, so please take this into account when needing to change your appointment date.

For a Monday or Tuesday appointment, we need to be notified no later than the Thursday prior, by noon.

Wednesday: by the previous Monday, by noon

Thursday: by the previous Tuesday, by noon

**No appointments can be cancelled over the weekend.

****Cancellations and reschedules CAN NOT be done over text message or voice mail**

We do understand that things come up, but due to the high amount of late cancellations and no-shows, this policy will be implemented on all appointments and for all patients. Adequate notice allows us to give that appointment slot to someone else that may be on our appointment waiting list.

Thank you for your understanding,

Golden Triangle Dentistry

I, _____ understand this policy and know if I do not cancel my appointment within the requested time frame that I will be charged.

X_____ Date:_____

Patient Signature