Welcome!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible. If you have any questions, or we can help you in

Patient Information (Confidential):

Name_____ (If Child, parent/guardian name)_____

Birthdate_____ Sex_____ Age_____ Soc. Sec. #_____

Home Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Which phone number would you like us to use when confirming? (please circle one) Home Work Cell

Email Address_____ Drivers License #_____

Employer_____ Occupation_____ How long there?_____ May we call?_____

Employer Address_____ City_____ State_____ Zip_____

Spouse's Name (or other patient/guardian)_____ Soc. Sec. #_____

Spouse's Employer_____ Occupation_____ How long there?_____ May we call?_____

How did you hear about our practice? (circle one) Mail Newspaper Website Other:_____ or Referred by:_____

Primary Insurance:

Name of Insured_____

Birthdate_____Relationship to patient_____

Address (if different from patient)_____

Dental Insurance Co._____ Phone_____

Soc.Sec.#_____ Subscriber ID#_____

Additional Insurance:

Name of Insured_____

Birthdate_____Relationship to patient_____

Address (if different from patient)_____

Dental Insurance Co._____ Phone_____

In case of emergency:

Someone we may contact, not living with you:_____ Phone Number_____

Authorization:

I authorize my insurance company to make payments directly to the dental office of Dr. Thomas Gibbs for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize us of this signature for all insurance submissions.

I understand the office policy of appointments needing to be changed or cancelled with at least a 48 hour notice otherwise a fee may be charged or a deposit required for future appointments.

I understand that I am responsible for all charges, including cancelation fees or deposits, whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card for any unpaid balances, including those after insurance payment. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts. **SERVICE CHARGE** If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) at an annual rate of 18%

I authorize Dr. Gibbs' office to use clinical photography (not full face) of myself in professional or promotional materials.

Signature_____ Date_____

Patient or Responsible Party

Medical History

Are you currently taking any medications? Yes _____ No _____

If yes, what? _____

_____

CHECK any of the following that you have had or have presently:

____Heart disease	____Heart Attack	____Artificial Heart Valve	____Heart Surgery
____Heart Murmur	____Heart Pacemaker	____Congenital Heart Lesions	____Abnormal Blood Pressure High/Low
____Hemophilia	____Abnormal Bleeding	____Anemia	____Sickle Cell Disease
____Bruise Easily	____Rheumatic Fever	____Scarlet Fever	____Liver Disease
____Thyroid Disease	____Arthritis	____Rheumatism	____Hepatitis, Which_____
____Pain in Jaw Joint	____Artificial Prosthesis	____Dizzy Spells	____X-ray or Cobalt Treatment
____Nervousness	____Diabetes	____Ulcers	____Epilepsy or Seizures
____Emphysema	____Tuberculosis (TB)	____Kidney Problems	____Unexplained Weight Loss
____Hay Fever	____Sinus Troubles	____Fever Blisters	____Chemotherapy: Cancer or Leukemia
____Cosmetic Surgery	____Night Sweats	____Respiratory Conditions	____Immune Deficiency Syndrome
____Glaucoma	____Fainting	____Drug Addiction	____Joint Replacement, Which_____

Do you experience any of the following: ___Jaw Pain/Clicking ___Morning Headaches ___Daytime Sleepiness/Fatigue ___Snoring

Other _____

Are you under a physician's care now? Yes ___ No___ If yes, for what? _____

Are you allergic or have you reacted adversely to any of the following:

____Aspirin	____Vicodin/Other	____Erythromycin
____Darvon	____Local Anesthetic	____Latex
____Nitrous Oxide	____Codeine	____Iodine
____Penicillin	____Valium	____Sulfa

Are you aware of being allergic to any other medications? Yes _____ No _____

If Yes, what? _____

_____

Have you ever had to pre-medicate for a dental visit? Yes _____ No _____

Family Physician _____ Address _____

City _____ State _____

May we request your health records if needed? Yes _____ No _____

Are you pregnant at this time? Yes _____ No _____ If yes, how many months _____

Any hospital visits within the last 2 years_____ If yes, why_____

_____

Is there any other medical or dental information you feel we should know? _____

_____

Please list any immediate family members and or personal representatives you authorize the office of Dr. Thomas Gibbs to communicate your health care, condition and scheduling with _____

_____

Signature: _____ Date;_____

Patient or Responsible Party

Dr. Thomas Gibbs
Dental History

Patient Name: _____ Date: _____

What is the reason for today's visit? _____

Date of last dental visit _____ Reason _____

Date of last cleaning _____ Last x-rays _____

Previous dentist's name _____

Address _____

Have you had complications with any previous dental treatment? _____

If yes, please explain:_____

How often do you have dental check-ups? _____

How often do you brush? _____ Floss?_____

What dental aides do you use? _____

What dental problems do you have now?_____

_____

Are any of your teeth sensitive to: (please circle)

Hot or cold? YES NO

Sweets? YES NO

Biting or chewing? YES NO

Do you get cold sores or lesions? YES NO

Do you notice mouth odors or bad tastes? YES NO

Do your gums bleed or hurt? YES NO

Any loose teeth or change in your bite? YES NO

Does food tend to get caught anywhere? YES NO

Do you smoke/chew tobacco? YES NO

Do you clench or grind your teeth? YES NO

Do you mouth breathe while awake/asleep? YES NO

Have you noticed clicks or popping of the jaw? YES NO

Do you have difficulty opening or closing? YES NO

Do you have pain or difficulty chewing? YES NO

Are your jaws tired in the morning? YES NO

I'm happy with the appearance of my teeth. YES NO

Rate your smile (on a scale of 1 to 10) _____

Do you want to keep all of your teeth for life? YES NO

Have you ever had:

Orthodontic treatment? YES NO

Oral Surgery? YES NO

Periodontal treatment? YES NO

A bite plate or mouth guard? YES NO

A serious injury to the mouth or head? YES NO

Your teeth ground or bite adjusted? YES NO

Pain in jaw, joint, ear or side of face? YES NO

Do you feel nervous about today's visit? YES NO

What is your biggest concern? _____

What did you like best about your last dental office?_____

_____

What did you like least?_____

Have you had an upsetting dental experience? YES NO

If so, what was it?_____

Is there anything else we should know?_____

_____

Please rank the following in the order they would KEEP you from having dental work:

1. Fear of pain _____
2. Cost of Treatment _____
3. Missing time from work _____
4. Embarrassed by dental condition _____

Dr. Thomas R. Gibbs, D.D.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of
YOUR NAME

Privacy Practices.

_____
{Signature}

_____
{Date}

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

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____

_____

_____

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.