GARDNER & GARDNER
D.M.D., P.C.

Family Dentistry

Steve Gardner, D.M.D.
Stacey Strickland Gardner, D.M.D.

PATIENT INFORMATION

Date _____

Last Name _____ First _____ Middle Initial _____

Address _____

City / State _____ Zip _____

Date of Birth _____ Marital Status: Married ____ Unmarried ____ Widowed _____

Home Phone _____ Business Phone _____

Social Security Number _____ Age _____

Occupation _____ Employer _____

Employer Address _____

Employer Phone _____ Length of Employment _____

Person Responsible for Account (If Different Than Patient)

Name _____

Address _____

Employer _____ Business Phone _____

Employer Address _____

Length of Employment _____

DENTAL INSURANCE INFORMATION

Name of Insurance Company _____

Group or Policy # _____ Phone No. _____

Policy Holder's Name _____ D.O.B. _____

Social Security Number of Policy Holder _____

Employer of Policy Holder _____

Person to Contact in an Emergency _____

Relationship _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you to our practice? _____

Has any other family member been treated in our office? _____

Please see other side

GARDNER & GARDNER, D.M.D., P.C.

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s), including non-prescription medicine?	☐	☐
If yes, what medications are you taking? _____		
4. Do you use tobacco?	☐	☐
5. Are you allergic to or have you had any reactions to the following?	☐	☐

	Yes	No		Yes	No
Local Anesthetics	☐	☐	Codeine	☐	☐
Penicillin or other Antibiotics	☐	☐	Aspirin	☐	☐
Sulfa Drugs	☐	☐	Other	☐	☐

6. Women only		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

7. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Leukemia	☐	☐	Emphysema	☐	☐
Heart Attack	☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐
Rheumatic Fever	☐	☐	AIDS or HIV Infection	☐	☐	Hepatitis/Jaundice	☐	☐
Fainting/Seizures	☐	☐	Thyroid Problem	☐	☐	Stroke	☐	☐
Cardiac Pacemaker	☐	☐	Asthma	☐	☐	Tuberculosis	☐	☐
Heart Murmur	☐	☐	Epilepsy/Convulsions	☐	☐	Other_____	☐	☐
Heart Valve Replacement	☐	☐						

PATIENT DENTAL HISTORY

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/food?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/food?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Do you clench or grind your teeth?	☐	☐
8. Have you had any orthodontic work?	☐	☐
9. Have you ever had any prolonged bleeding following extractions?	☐	☐
10. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
11. Have you ever had instructions on the care of your gums?	☐	☐

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services, and may send check to me. I hereby unconditionally guarantee payment for all dental services rendered on my behalf or my dependents. I agree to pay attorney's fees in the event any debt for such services is placed in the hands of an attorney for collection.

X _____

Signature of patient or parent if mino

Financial Policy for Gardner & Gardner, D.M.D.

Thank you for choosing the office of Gardner & Gardner, D.M.D. to provide you dental care. We are committed to the success of your treatment and care. Please understand that payment of your bill is part of this process. The following is our Payment at the Time of Service Policy, which we repuest all our patients read, understand and sign prior to any course of treatment.

WHEN IS PAYMENT DUE?

Payment for office visits and office procedures is due at the time services are rendered in the office, (UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE). To see how this affects your specific insurance situation, please read the "About Your Insurance Coverage" section of this policy thoroughly.

METHODS OF PAYMENT

We accept cash, personal check, Visa, Mastercard, Discover, and American Express. We offer payment plans and are happy to provide financial counseling if necessasy. Please ask for the Financial Co-ordinator , if you wish to discuss alternate payments plans.

ABOUT THE FEES WE CHARGE

Our fees are comparable to other dental providers in Alabama. We feel confident that our charges are appropriate. If you have any questions about our fees, please ask us.

PATIENTS WHO ARE MINORS

The adult accompanying a minor and the parents (or guardians) are responsible for payment. For unaccompanied minors, non-emergency treament will be denied unless charges have been preauthorized to an approved credit plan, including payment draft of Credit Card, or payment is mde by cash or check a the time of visit.

ABOUT OUR INSURANCE COVERAGE

The amount that is due at the time of service may vary, according to your insurance policy. Please note the following guidelines:

As a courtesy, our office staff will file you insurnace claim for you. BECAUSE WE ARE NOT A PART OF THE CONTRACT BETWEEN YOU AND YOUR INSURANCE, YOUR ACCOUNT BALANCE IS YOUR RESPONSIBILITY WHETHER YOUR INSURANCE COMPANY PAYS OR NOT. If there is a remaining balance after the insurance has paid, you will be billed for the difference. If insurance makes payment directly to you, the subscriber, we ask that you sign and forward the payment to our office, along with the explanation attached.

Please be aware that some services may not be a covered benefit under your plan. In that case, all non-covered services are your responsibility to pay in full the day services are rendered. In consideration of the professional services rendered to me, or at my request by Dr. Steve or Dr. Stacey Gardner, I agree to pay therefore the reasonable value of said services to the Doctor, or his/her assignee, at the time services are rendered, OR by next billing cycle if credit is extended. I further agree that reasonable value of services shall be billed to and paid by me: further, if a waiver of breach of this agreement should occur, I understand that my account may be forwarded for collection efforts and agree to pay all reasonable court costs and fees if suit be instituted.

I grant permission to you or your assignee to telephone me at home or work to discuss matters related to this form. I HAVE READ AND UNDERSTAND THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THERE CONTENT.

(THIS OFFICE IS A FEE FOR SERVICE, NOT A NETWORK PROVIDER)

Signature of Responsible Party _____ Date _____

I have received a copy of this office's notice of privacy practices.

Signature _____ Date _____