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 ______________________

Cell Phone ______________________ Email ______________________

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 ______________ Cell 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

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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 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 minor

Financial Policy for Gardner Family Dentistry

Thank you for choosing the office of Gardner Family Dentistry to provide your 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 request all our patients read, understand and sign prior to any course of treatment.

WHEN IS PAYMENT DUE?

Payment for office visits and office procedures are 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. We also offer the Gardner Family Dentistry Dental Savings Plan. 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/or 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 financial plan.

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 your 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 of benefits attached.

"I am aware that some services may not be a covered benefit under my plan. In that case, all non-covered services are my 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. Further, in the event of default, if my account is sent to a third party attorney for collection, I agree to pay a reasonable attorney's fee, as well as any court costs or other expenses."

"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 IT'S 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 ______________