Patient Name:_____
Date: _____

Welcome!!!

As a new patient to our dental practice we would like to extend you a warm welcome. Our practice is committed to ensuring that each visit here is as comfortable as possible. Dr. Gordley's philosophy is to provide gentle, quality dental care for his patients in a relaxed environment. You can expect to be treated like family at our office. Please let us know if there is anything we can do to help your visit to be more enjoyable.

Sincerely,

Your New Dental Family

Please take a moment to let us know how you heard about us:

____Referred by a friend (please let us know who to thank)
_____

____Website

____Drove by the office and thought you would try us

____Yellow pages

____Other (please specify)
_____

DENTAL PATIENT MEDICAL HISTORY

Name (Last, First, MI) Birthdate (Month, Date, Year)

Home Address (Street, City, State, Zip) Home Phone: Work Phone:

PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE:

1. Please draw a circle around any of the following, which you have had or have at present.

Heart Disease or Condition	Rheumatic Fever	Asthma	Hepatitis	Venereal Disease (Syphilis, Gonorrhea)
Angina Pectoris (Chest Pain)	Stroke	Hay Fever	Thyroid Disease	Drug Addiction
High Blood Pressure	Hemophilia	Emphysema	Epilepsy/Seizures	Psychiatric Treatment
Shortness of Breath	Bruise Easily	Tuberculosis	Glaucoma	Cancer
Swollen Ankles	Prolonged Bleeding	Diabetes	Fainting Spells	Radiation Treatment
Artificial Heart Valves	Anemia	Ulcers	AIDS or ARG	Chemotherapy
Congenital Heart Disease	Blood Transfusion	Kidney Problems	HIV positive	Implant Prosthesis
Heart Murmur	Sickle Cell Disease	Liver Disease	Cold Sores	Unexplained Weight Loss
Arthritis	Jaundice	Genital Herpes		

CIRCLE YES OR NO FOR EACH OF THE FOLLOWING:
(CONTINUE ON BACK IF NECESSARY)

2. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER A PHYSICIAN'S CARE IN THE PAST YEAR? YES NO

3. ARE YOU PRESENTLY TAKING ANY MEDICATIONS OR SUPPLEMENTS? YES NO

4. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS ? YES NO

5. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC? YES NO

6. HAVE YOU EVER EXPERIENCED ANY DISEASE , COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT? YES NO

7. DO YOU HAVE ANY DISEASE OR CONDITIONS NOT LISTED ABOVE? YES NO

8. HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR ? YES NO

9. DO YOU USE TOBACCO PRODUCTS ? YES NO

10. WOMEN: ARE YOU PREGNANT? YES NO NURSING? YES NO TRIMESTER? 1 2 3

HAVE YOU ADDED ON THE BACK? YES NO

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN) ***DATE***

DENTISTS COMMENTS:

Dentist's Signature Date Reviewer Date Reviewer Date Reviewer Date

Patient Information

Patient Name :_____ Date :_____
Last First MI (preferred name)

Male/Female __ Married __Single __Child Birth Date:_____ Social Security # :_____

Address:_____
Street City State Zip Code

Email Address: _____ Home Phone:_____

Cell Phone:_____ Work Phone:_____

What is the way to reach you? (Email, Cell, Home, etc.) _____

Responsible Party Information

The following is for the person responsible for payment: __ Self __Spouse __Parent or Guardian

Name:_____ Relationship:_____
Last First MI (preferred name)

Male/Female __ Married __Single __Child Birth Date:_____ Social Security #:_____

Address:_____
Street City State Zip Code

Email Address: _____ Home Phone:_____

Cell Phone:_____ Work Phone:_____

Insurance Information

Insurance Plan Name:_____ Insurance Phone #:_____

ID#:_____ Group #:_____ Policy Holder's Birth Date:_____

Policy Holder's Employer: _____

Name of Policy Holder: _____ Is this person a patient at our office? Y or N

Insurance Company's Address:_____
Street City State Zip Code

If there is Secondary Insurance Coverage, please list that information below:

Insurance Plan Name:_____ Insurance Phone #:_____

ID#:_____ Group #:_____ Policy Holder's Birth Date:_____

Policy Holder's Employer: _____

Name of Policy Holder: _____ Is this person a patient at our office? Y or N

Insurance Company's Address:_____
Street City State Zip Code

If there was a simple, inexpensive way to whiten your teeth – would you be interested?

If you could change one thing about your smile – what would it be?

What have you liked most about any dental office you have been to before?

What have you liked the least?

Are you interested in avoiding bad breath?

Are you interested in a non surgical way to stop your spouse from snoring?

Insurance and Financial Policy

We believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initial

_____Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefits will never pay for completion of your dental care. It is only meant to assist you.

_____We currently process all insurance plans. This means we work with literally hundreds of companies. Although we can maintain computerized histories of payments by a given company, they do change, therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

_____We will bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____We do require payment in full for your portion at the time of service. We accept Visa, MasterCard, cash, and checks. If you are in need of extended finance options, we also work with CareCredit, a company who offers 3 or 6 months interest free financing. CareCredit also has extended terms designed to meet your treatment plans on approved credit.

_____A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we ask that you give at least a 24 hour notice.

_____In the event of an emergency after regular business hours, a $148.00 fee will be charged in addition to the necessary treatment fees.

I agree with the above conditions.

Print Name:_____Date:_____

Patient/Parent Signature:_____

David L. Gordley D.D.S., LLC
340 Franklin Street
Slippery Rock, PA 16057

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone #_____ E-Mail_____

Social Security #_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available to you. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: (Office Manager) 340 Franklin St. Slippery Rock, PA 16057
Telephone: 724-794-2000 Fax: 724-794-4546

Right to Revoke: You will have the right to revoke this Consent at any time, by giving us written notice of your revocation submitted to the contact persona listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

David L. Gordley D.D.S., LLC
340 Franklin St.
Slippery Rock, PA 16057

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 Privacy Practices.

_____
Please print name

_____
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)

_____
_____
_____
_____
_____
_____