Dr. Lindsey Clark-Fass, DDS, PC
Dr. C.J. Gossett, DDS

PATIENT INFORMATION

CONFIDENTIAL

Date: _____

Please Print:

Name_____SS#_____Birthdate_____Home Phone_____

Cell_____Work_____Email_____

Address: _____City/State/Zip_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patients or Parents Employer _____Address_____

Spouse or Parent's Name_____Employer_____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY/ INSURANCE INFORMATION

Name/Relationship of Person Responsible for this Account_____Birthdate_____SS#_____

Employer/Address_____Phone_____

Insurance Company/Address_____Group#_____

How much is your Deductible? _____How much have you used? _____Max. Annual Benefit? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No If YES, Complete the Following:

Name of Secondary Insured_____Birthdate_____SS#_____

Employer/Address_____Phone_____

Insurance Company/Address_____Group#_____

How much is your Deductible? _____How much have you used? _____Max. Annual Benefit? _____

IN THE EVENT OF EMERGENCY

Whom should we contact? _____Relation_____

Home Phone _____Cell Phone _____Work home_____

Who is your Medical Doctor? _____Doctor's Phone_____

DISCLAIMER

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

_____ Patient/Guardian Signature

PATIENT DENTAL HISTORY

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation ☐ Cleaning

Are you in pain? ☐ No ☐ Yes How Long? _____

Please indicate ☑ any of the following problems:

☐ Discomfort, clicking or popping in jaw	☐ Lost/Broken filling(s)	☐ Stained teeth	☐ Teeth grinding
☐ Red, swollen or bleeding gums	☐ Locking jaw	☐ Ringing in Ears	☐ Bad Breath
☐ Blisters/Sores in or around the mouth	☐ Sensitive tooth, teeth or gums	☐ Broken/Chipped teeth	

☐ Other: _____

Previous Dentist: (Name)_____(Phone)_____

Date of last dental exam: _____ Date of last dental X-rays:_____

How many times per day do you brush? _____ How many time per week do you floss? _____

What type of toothbrush bristles do you use? ☐Soft ☐Medium ☐Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

What medications are you taking? ☐ Nerve pills ☐ Pain killers(including aspirin) ☐ Muscle relaxers ☐Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis(Bisphosphonate)

PLEASE LIST ALL MEDICATIONS: _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

☐Heart Attack / Stroke	☐Thyroid Problems	☐Cancer / Tumors	☐Hepatitis
☐Heart Surg / Pacemaker	☐Kidney Problems	☐Shingles	☐Difficulty Breathing
☐Heart Murmur	☐Jaw Problems	☐Rheumatic Fever	☐Liver Problems
☐HIV+ / AIDS / ARC	☐Mitral Valve Prolapse	☐Respiratory Problems	☐Arthritis / Rheumatism
☐Artificial Valves	☐Sinus Problems	☐Artificial Bones / Joints	☐Heart Disease
☐Stomach Problems / Ulcers	☐Emphysema	☐Congenital Heart Defect	☐Psychiatric Problems
☐Fainting / Seizures / Epilepsy	☐Chest Pains	☐Venereal Disease	☐Severe / Frequent Headaches
☐Scarlet Fever	☐Alcohol / Drug Abuse	☐Frequent Neck Pain	☐Nervousness
☐Tuberculosis TB	☐Back Problems	☐Cosmetic Surgery	☐X-ray or Cobalt Treatment
☐Chemotherapy	☐Asthma	☐Diabetes / Hypoglycemia	☐Leukemia
☐Anemia	☐Glaucoma	☐High / Low Blood Pressure	

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Please list any other surgeries or medical conditions you have or ever had:

_____

Are you Allergic to any of the following? ☐Latex ☐Penicillin/Amoxicillin ☐Tetracycline ☐Aspirin

☐ Dental Anesthetics ☐Foods: _____ ☐Others: _____

Do you use tobacco? ☐No ☐Yes/How used? _____ How Much? _____ How Long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ☐ Yes ☐ No

Have you ever taken the drug Phen-fen and and or Redux? ☐ Yes ☐ No

For women: Are you taking birth control pills? ☐Yes ☐No How many children have you had? _____

Are you pregnant? ☐No ☐Yes/How Long? _____ Are you nursing? ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager, if account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of you Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA: I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____

Practice Name:
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