TRUSSVILLE DENTISTRY
DR. NANCY GAFFORD

205-661-2201 • 3713 Mary Taylor Road Birmingham, AL 35235

Date: _____

PLEASE FILL IN ALL INFORMATION COMPLETELY

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ CELL # _____

WORK # _____

EMAIL _____ DATE OF BIRTH: _____

SEX _____ **SELECT ONE:** SINGLE MARRIED DIVORCED WIDOWED

SOCIAL SECURITY NUMBER _____

F/T STUDENT: YES NO WHERE _____

YOUR EMPLOYER _____ PHONE # _____

WHO TO NOTIFY IN CASE OF EMERGENCY: _____
NAME NUMBER

HOW DID YOU HEAR ABOUT US?

SELECT ONE: INTERNET OUR WEBSITE FACEBOOK YELLOW PAGES

FRIEND/FAMILY MEMBER _____

STAFF MEMBER _____

OTHER _____

NAME _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO _____

SUBSCRIBERS NAME (POLICY HOLDER) _____

EMPLOYER OF POLICY HOLDER _____

SUBSCRIBER'S SOCIAL SECURITY # _____ BIRTH DATE _____

CONTRACT OR ID # _____ GROUP # _____

SECONDARY INSURANCE CO _____

SUBSCRIBER'S NAME (POLICY HOLDER) _____

ADDRESS OF SUBSCRIBER _____

PHONE OF SUBSCRIBER _____

SUBSCRIBER'S SOCIAL SECURITY # _____ BIRTH DATE _____

CONTRACT OR ID # _____ GROUP # _____

CONSENT FOR TREATMENT

I hereby authorize Dr. Gafford to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Gafford to make a thorough diagnosis of my dental needs. I also authorize Dr. Gafford to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals.

SIGNATURE _____

DATE _____

NAME _____

DENTAL/MEDICAL HISTORY

REASON FOR TODAY'S VISIT? _____

DATE OF LAST DENTAL VISIT _____ LAST CLEANING _____ LAST X-RAYS _____

WHAT WAS DONE ON YOUR LAST DENTAL VISIT? _____

PREVIOUS DENTIST _____

HOW OFTEN DO YOU HAVE DENTAL EXAMS? _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____

WHAT OTHER DENTAL AIDS DO YOU USE? (ELECTRIC TOOTHBRUSH, WATERPIK, ETC) _____

_____

Teeth sensitive to Hot or Cold?	YES	NO
Teeth sensitive to Sweets?	YES	NO
Teeth sensitive to Biting/Chewing?	YES	NO
Have you noticed mouth odor or bad taste?	YES	NO
Do you have sores or blisters?	YES	NO
Do your gums bleed or hurt?	YES	NO
Have your parents experienced gum disease?	YES	NO
Any loose teeth or change in your bite?	YES	NO
Do you clench or grind your teeth?	YES	NO
Do you bite your cheeks or gums?	YES	NO
Do you breath with your mouth open?	YES	NO
Do you snore or have sleeping disorders?	YES	NO
Have you have or had braces?	YES	NO
Had oral surgery?	YES	NO
Have you have/had a mouth guard?	YES	NO
Had serious mouth injury?	YES	NO
Have you had clicking or popping of the jaw?	YES	NO
Have you had any head pain (ears, neck)	YES	NO
Difficulty opening mouth?	YES	NO
Problem chewing on one side of mouth?	YES	NO
Are you satisfied with your teeth/smile?	YES	NO

NAME _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE NUMBER _____

LAST VISIT WITH PHYSICIAN _____

Have you ever been hospitalized/major operation? YES NO

Have you ever had a serious head or neck injury? YES NO

Do you smoke? YES NO If yes, how much per day? _____

Do you use chewing tobacco ? YES NO If yes, how often? _____

Do you consume alcohol? YES NO If yes, in what quantities? _____

Do you take blood thinners? YES NO If yes, what? _____

Do you use controlled substance? YES NO If yes, what? _____

Do you have to pre-medicate for dental procedures? YES NO If yes, what? _____

Are you currently taking prescription medications? YES NO If yes, please list below:

NAME OF MEDICATIONS

_____ _____

_____ _____

_____ _____

PLEASE CIRCLE IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING

ASPIRIN PENICILLIN CODEINE ACRYLIC LATEX METAL DENTAL ANESTHETIC

ARE YOU ALLERGIC TO ANY OTHER MEDICATIONS? YES NO

IF YES, PLEASE EXPLAIN _____

FOR WOMEN: ARE YOU PREGNANT? YES NO IF YES, HOW MANY MONTHS? _____

TAKING ORAL CONTRACEPTIVES? YES NO NURSING YES NO

NAME _____

PLEASE CIRCLE IF YOU HAVE, OR HAVE EVER HAD, OR BEEN TREATED FOR THE ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS

AIDS/HIV	Epilepsy	Mitral Valve Prolapse
Allergies (Seasonal)	Excessive Bleeding	Nervous Disorder
Anemia	Facial/Head Injuries	Pacemaker
Arthritis	Fainting	Prosthetic Valves
Artificial Heart Valve	Glaucoma	Psychiatric Problems
Asthma	Headaches	Radiation
Blood Disorder	Heart Conditions	Respiratory Problems
Cancer	Heart Murmur	Rheumatic Fever
Chemotherapy	Hepatitis/Jaundice	Rheumatism
Depression	High Blood Pressure	Scarlet Fever
Diabetes	Jaundice	Seizures
Digestive Problems	Joint Implants	Stomach Problems
Dizziness	Kidney Problems	Stroke
Drug/Alcohol abuse	Liver Disease	Thyroid Disease
Eating Disorders	Low Blood Pressure	Tuberculosis
Emphysema	Ulcers	Venereal Disease

HAVE YOU BEEN TREATED FOR ANY OTHER ILLNESS NOT LISTED ABOVE? YES NO

IF YES, PLEASE EXPLAIN _____

_____

_____

_____

_____

_____

_____

_____

FINANCIAL POLICY

WE REQUIRE PAYMENT AT THE TIME OF YOUR VISIT

We make every effort to keep down the cost of your dental care which requires us to promptly collect payment for our services to avoid additional cost. If your treatment program requires several visits, you will be given an estimate and offered to discuss definite arrangements with a member of our staff.

YOU ARE RESPONSIBLE FOR INSURANCE PAYMENTS

Please understand that no insurance attempts to cover all costs involved in your dental care. Some pay fixed allowances for certain procedures and others pay a percentage of the fee. You are responsible to pay a deductible amount, coinsurance, or any other balance not paid by your insurance. In the event your carrier has not or will not pay on your behalf within 30 days, it is your responsibility to pay your account and settle disagreements with your insurance company. We will attempt to answer any question we can about your insurance but cannot speak on their behalf as your insurance contract is with the company and not Trussville Dentistry, P.C. We will gladly, at no charge, file your claim on primary and secondary insurance.

OTHER CHARGES

Returned check fee: $30.00
Service Charge on unpaid balance: 1.5% monthly
Collection fees on unpaid balance: You are responsible and agree to pay all costs of collecting or attempting to collect your debt, including attorney's fees.

NAME _____ DATE _____

WITNESS _____

PRIVACY POLICY

I have received a Notice of Trussville Dentistry's Privacy Practices or have been offered a copy.

NAME _____ DATE _____

WITNESS _____

☐ **Patient refused to sign**
☐ **Communication barriers prohibited obtaining the acknowledgment**
☐ **An emergency situation prevent us from obtaining acknowledgment**