gustafson morningstar dentistry

Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number		Drivers License Number	Date of Birth
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

Person Responsible For Account ~ ☐Check Here If Same As Above

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number		Drivers License Number	Date of Birth
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

Dental Insurance Information

☐Check here if you do not have Dental Insurance ☐Check here if you previously provided information

Insured's First & Last Name	Date of Birth	Social Security
Name of Insured's Employer		Patient Relationship To Insured
Insurance Company	Phone	Subscriber ID #	Group ID #
Insurance Company Address	City	State	Zip

Referral Information

How did you **first** hear about our office? ☐Another Patient (relative) ☐Another Patient (friend) ☐New Patient Flyer ☐Another Dental or Medical Office ☐School ☐Work ☐Drive By Office ☐Google ☐Yelp ☐ Facebook ☐Yellow Pages ☐Employee ☐Community/Charity Event ☐Insurance Company ☐Health/Benefits Fair or Event

If someone referred you to us please write his or her name:

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Informed Consent For Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information may be used to:

- Conduct, plan, direct my treatment, and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. My signature will also serve as a release should I request treatment or radiographs be sent to other attending Doctors in the future.
- Obtain payment from third-party payers in your behalf, i.e. dental insurance.
- Conduct normal healthcare operations such as quality assessments and required local/federal certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, financial or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize Gustafson and Morningstar DDS PC and its employees to contact me with information regarding my dental appointments, treatment, billing, health, and services.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Please list any other parties who can have access to your dental information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have been informed & consent to these notices & release information to the above person(s)

_____

Patient Name (print)

_____

Patient/Guardian (Signature) Date

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Dental Health History

(Please Print) Patient First Name Patient Last Name Date

Please check any of the following that apply to you:

- ☐ Sensitivity to: Hot Cold Sweet
- ☐ Chipped / Broken Teeth
- ☐ Crooked or Tipped Teeth
- ☐ Loose Teeth
- ☐ Missing or Spaces Between Teeth
- ☐ Catch Food Between Teeth
- ☐ Dry Mouth or Constantly Thirsty
- ☐ Smoke or Use Chewing Tobacco
- ☐ Bleeding, Swollen or Irritated Gums
- ☐ Dissatisfied With Appearance of My Teeth
- ☐ Frequent Headaches
- ☐ Jaw Joint Pain
- ☐ Grinding or Clenching Teeth
- ☐ Uncomfortable or Uneven When I Bite My Teeth Together
- ☐ Clicking or Popping of Jaw
- ☐ Difficulty Opening or Chewing

Do you have, or have you had any of the following:

- ☐ Dentures or Partials
- ☐ Braces or Clear Braces
- ☐ Periodontal Disease or Gum Treatments
- ☐ Fixed Bridge
- ☐ Dental Implants
- ☐ Crowns
- ☐ Veneers
- ☐ Jaw Surgery
- ☐ Root Canals
- ☐ Sleep Apnea
- ☐ C-PAP Machine or Oral Sleep Appliance
- ☐ Fear or Anxiety About Dental Treatment

If I could change my smile, I would:

- ☐ Make My Teeth Whiter
- ☐ Make My Teeth Straighter
- ☐ Close Spaces or Gaps That Bother Me
- ☐ Replace Dark Metal Fillings With Tooth Colored Fillings
- ☐ Fix My Teeth So I'm Not Embarrassed When I Smile
- ☐ Repair Chipped Teeth
- ☐ Replace Missing Teeth
- ☐ Replace Old Crowns That Look Dark or Don't Match
- ☐ Have a Smile Makeover
- ☐ Stop My Jaw From Hurting or Clicking

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

Tell me about my options for replacing missing teeth with Dental Implants? ☐ Yes ☐ No

Tell me how I can straighten my teeth with clear braces and if I'm a candidate? ☐ Yes ☐ No

Have you ever been sedated for dental treatment? ☐ Yes ☐ No

Are you interested in sedation options? ☐ Yes ☐ No

Have you ever whitened your teeth? ☐ Yes ☐ No

If this is your first time in our office please answer the following:

Date of last cleaning? ___/___ Date of last oral cancer screening ___/___ Date of last complete x-rays? _____

What is the most important thing to you about your dental visit today? _____

Why did you leave your previous dentist? _____

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Medical Health History

(Please Print) Patient First Name Patient Last Name Date

Please check any of the following that apply to you:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Lesions (Congenital)
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis: A B C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervousness / Depression
- ☐ Pacemaker
- ☐ Periodontal Disease
- ☐ Radiation (Head / Neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Women Only

- ☐ *Birth Control*
- ☐ *Nursing*
- ☐ *Pregnant*:

Delivery Date: _____

Do you have any of the following drug allergies?

- ☐ Aspirin
- ☐ Codeine
- ☐ Darvon
- ☐ Erythromycin
- ☐ Latex
- ☐ Anesthetic
- ☐ Nitrous Oxide
- ☐ Sulfa
- ☐ Percodan
- ☐ Penicillin
- ☐ Antibiotics
- ☐ Foods
- ☐ List Other Allergies

_____

_____

_____

Please check any of the following drugs you have used at any time:

- ☐ Fosamax
- ☐ Aredia
- ☐ Didronel
- ☐ Actonel
- ☐ Zometa
- ☐ Skelid
- ☐ Boniva
- ☐ Bisphosphonates

List ALL medications you currently take. (Prescription, Over The Counter, Vitamins, Supplements. Attach List if Needed)

_____ _____ _____ _____

_____ _____ _____ _____

Using the Epworth Sleepiness Scale of 0-3, how likely are you to doze off or fall asleep in the following situations?
0= No chance of dozing 1=Slight chance of dozing 2=Moderate chance of dozing 3=High chance of dozing

____Sitting and Reading

____Watching TV

____Sitting inactive in a public place, i.e. theater, meeting

____As a passenger in a car for an hour without a break

____Lying down to rest in the afternoon if conditions permit

____Sitting and talking to someone

____Sitting quietly after lunch without alcohol

____In a car, while stopped for a few minutes in traffic _____**Total Score**

If under physicians care for any condition please explain:

_____

_____

Physician's Name: _____

Physician's Phone: _____

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify Gustafson and Morningstar DDS PC of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements, I agree not to hold Gustafson and Morningstar DDS PC or its employees liable in the event of death or injury.

Signature (Patient/Guardian)_____Date: _____ Dentist Signature: _____

Financial Policy

Thank you for choosing our office, Gustafson Morningstar Dentistry, as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

☐ **Please check if you would like more information about financing options.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Signature _____ Date _____

(Patient or Guardian)

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Patient Photo Release Form

I hereby authorize Drs. Gustafson and Morningstar and / or any of their assignees to take photographs, slides, and / or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos **will** be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, social media, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name (First Name Only) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please initial:

_____I do not mind if my first name, face, and teeth are used in any of the above stated situations.

Exceptions:

_____I do not wish to have my First Name shown, or released.

_____I do not wish to have my face shown.

_____I only agree to have my teeth shown without any identifying features.

_____I do not wish to have my photos used at all.

Patient Name (print) _____

Patient Signature _____
(parent or guardian signature if patient is under 18)

Date_____