

Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

GS Dental LLC, 7910 Wyoming Blvd. Suite A, Albuquerque, NM 87109 505-883-5835

PATIENT INFORMATION

Name _____ [] Dr. [] Mr. [] Mrs. [] Ms. [] Rev. [] Other: _____
First MI Last
Address _____ Occupation: _____ [] Male [] Female
City _____ State _____ Zip _____ Hm# (____) _____
Employer _____ Wk# (____) _____ Ext _____
Are you: [] Minor [] Married [] Single [] Divorced [] Widowed [] Separated Cell # (____) _____
DOB: ____/____/____ SSN# _____ E-mail _____@_____
Spouse's Name _____
First MI Last (if different)
Spouse occupation _____ Work phone _____ Ext _____
Is patient a full time student? [] No [] Yes: Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last
Address _____
City _____ State _____ Zip _____
Hm# (____) _____
Wk# (____) _____
DOB: ____/____/____
SSN# _____
Relationship: _____

YOUR PREFERENCES

Do you prefer appointment reminders by:

[] Email [] Phone [] Text

Do you prefer to receive calls from our office at:

[] Home [] Work [] Cell

Whom may we thank for referring you?

How do you wish to be addressed by our staff?

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____
DOB: ____/____/____ Subscriber's SSN# _____
Insurance Company _____ Policy # _____ Group # _____

DENTAL INSURANCE:

Insured Name _____ Relationship to patient: _____
Address _____ City _____ State _____ Zip _____
DOB: ____/____/____ SSN# _____ Employer: _____
Insurance Company _____ Group # _____ Eff. Date: ____/____/____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [] Yes [] No If yes, please complete the following:

Insured Name _____ Relationship to patient: _____
Address _____ City _____ State _____ Zip _____
DOB: ____/____/____ SSN# _____ Employer: _____
Insurance Company _____ Group # _____ Eff. Date: ____/____/____



Our practice is one of the most advanced CAD/CAM practices in the US. We use 3-D CEREC technology to produce ceramic restorations in a single visit.

CONFIDENTIAL

"Our practice is dedicated to helping you have good oral health for a lifetime."

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

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

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician 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 the aforementioned document prior to signing this consent. I understand the organization has the right to change its policy from time to time and that I may contact this organization at any time at the address below to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that 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 understand that I may revoke this consent at any time in writing, except to the extent that you have taken action relying on this consent.

PATIENT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

Fred Giombolini, DDS
Ryan Sill, DMD
7910 Wyoming Blvd. NE, Ste., A
Albuquerque, NM 87109

GS Dental ~ Financial Policy

Our mission here at GS Dental is to help you afford the quality treatment that you deserve. We accept Visa, Mastercard, Discover and American Express. We also offer zero interest financing for up to 24 months to those who qualify, or longer terms with small interest charges. These plans allow you to make monthly payments. Application needs to be made prior to your appointment, and we usually receive approval in a short period of time.

We work with most dental insurers. Carriers vary, but we'll try to help you get the most out of your particular policy. As a courtesy to you, we will submit your claim forms for you, and answer any questions we can. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. We do require that you pay the portion that your insurance policy doesn't cover at the time of service.

Any remaining balance after 60 days becomes your responsibility, regardless of insurance coverage. At that point, you will be charged 1.50% per month on the remaining balance until it is paid in full.

Our goal is to provide you with the best possible treatment and the time we reserve for you enables us to provide you with the care you need. Any appointment broken without a 24 hour advance notice, excluding a medical emergency, will result in a cancellation charge of \$50.00.

_____ **Date**_____

Signature