Goose Creek Family & Cosmetic Dentistry

Thank you for choosing us! Your dental care is very important to us.

First Name: _________________ Last Name: __________________Birth date: ________
SS#: ______________ Male Female (please circle)

Address: _________________________City: __________State: ______Zip: _________

Home phone: ______________Work: ______________Cell phone: _________________

E-mail Address: ___________________Employed by: _____________________

Who carries dental insurance? __________________

Does this plan cover all family members? ______Yes ______No

Spouse's name: _________________Birth Date: ___________SS#________________

Spouse employed by: ______________________

In the event of an emergency, please notify: ____________________Phone#:________________

Why did you leave your last dentist?______________________________________

Who may we thank for referring you to our office:___________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I__________________ have received a copy of this office's Notice of privacy practices.
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.**
- ❑ **Communication barriers prohibited it.**
- ❑ **An emergency situation prevented us obtaining**
- ❑ **Acknowledgement.**
- ❑ **Other {Please specify}________________________**

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Adult: Medical and Dental History

Physician's Name: ___________________________________Phone #___________________
Date Last Complete Physical: ___________________

The treatment of your teeth, gums, jaws, and over all dental health is a combinations of many factors. The success of treatment depends on a thorough examination. All of the questions are related to your oral health. Each factor has a contributing influence.

Medical: Have you been hospitalized recently? ______Yes ______No
Are you taking any medications? ______Yes________No

If Yes List:____

____ Pacemaker
____ Heart Problems
____ Rheumatic Fever
____ Heart Murmur
____ Heart Attack
____ Stroke
____ Liver or Kidney Disease
____ Hepatitis
____ AIDS/HIV
____ High or low blood pressure
____ Diabetes
____ Epilepsy
____ Blood Transfusions {within the last 5 years}
____ Medications For Osteoporosis {BONE}

____ Thyroid
____ Tumors, Cancer
____ Joint Replacement
____ Endocrine/Glandular Disorder
____ Radiation Therapy
____ Asthma or Hay Fever
____ Blood Disorder /Blood Thinners
____ Respiratory Problems
____ T.B. or Pneumonia
____ Nervous / Emotional Disorders
____ Woman: Are you Pregnant

Drug Allergies: Please List: ____

Dental: **Do you have, or have ever had:**

1. Periodontal surgery? {Gum scaling / root planning}_____When?_____
2. Orthodontics {braces}?_____When_______
3. Partial Dentures or full dentures?_________
4. A fixed {permanent} bridge?______
5. Some mouth or acute pain?_______
6. Ulcers or sores in your mouth that do not heal? _______
7. Burning tongue? _____
8. Bleeding gums? ______
9. Unpleasant mouth odor or taste? ________
10. Collections or wedging of food between teeth? ______Where_____________________________
11. Jaw problems {example: aching, clicking, popping, out of joint}? _________________________
12. Clenching or grinding of teeth? __________
13. If you have partial or full dentures, do you wear them? _________
14. Are you self conscious about you smile? ___________
15. Do you need dental floss instruction? ___________
16. Do you feel that you may need to see a gum specialist? ___________

Please tell us in one or two sentences, what are your thoughts about your teeth and gums, and how we can help you: ____
____

Health History Verified____________ ***Signature***________________________________***{patient}***
Staff_______________ Dr._____________

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Financial Responsibility Agreement and Consent for services

Ryan N. Gilreath, DMD Scott R. Antonio, DMD Andrew J. Ponton, DMD

We gladly accept all Major Credit Cards & we will promptly file your Dental Insurance as a courtesy to you. Please bring in your benefit booklet or insurance ID Card.
We know questions can arise on insurance matters, so we encourage you to discuss such questions with our staff. We will be happy to help you receive the maximum benefits, however; **The agreement of the insurance company to pay your dental care is a contract between you, your employer and your employer's insurance company. Please note that insurance estimates and pre-estimates are not a guarantee from your insurance company.** The deductible and or the percentage that the insurance company does not cover is due as the dental care is completed. For Patients with dental insurance, please read and sign below. This will expedite the filing of your insurance claim and eliminate your having to sign each form.

I authorize the release of any information needed for filing dental claims and authorize payment directly to Dr. Ryan Gilreath, Dr. Scott Antonio, & Dr. Andrew Ponton
Sign:____Date:__________

Payment Policies:As a condition of treatment by this office, financial agreements must be made in advance. We will discuss financial options with you before rendering treatment.
By signing below, you are agreeing to all of the terms contained in this Financial Responsibility Agreement.

1. Payments is due in full at the time of service unless prior written financial arrangements have been made.
2. There is a $50 service charge on all returned checks.
3. We reserve the right to charge a $50 missed appointment fee for no-shows or cancellations with less than 24hrs notice.
4. I understand and agree that any account balance not paid within 90 days will be subject to collection activity.
5. I understand and agree that, ultimately, I am responsible for payment on my account. As a guarantor, I am responsible for any outstanding balances for other family members listed on the same account, due to Goose Creek Family Dentistry.

Print Patient Name: ________________________________ Sign: ___________________________

Guarantor Signature: ____ Date: _______________

If you are happy with our services, please refer us to a friend.
A referral is the best compliment you can give us!
Please like us on Facebook for special promotions!

Goose Creek Family Dentistry Consent
For Dental Treatment during COVID-19 Outbreak

1. I, ____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic at Goose Creek Family Dentistry.
2. I understand that carriers of the COVID-19 virus may not exhibit any symptoms, and if they do, the virus has a long incubation period of up to 14 days or longer before symptoms are apparent. Therefore, prior to confirmation of the infection with specific COVID-19 testing, it is impossible to determine who has been infected with and can transmit it to others. _______________ (Initials)
3. I understand that the CDC recommends social distancing of at least six (6) feet to reduce the transmission of the virus, and that this is impossible with dental treatment. ________________ (Initials)
4. Has anyone in your household been tested for COVID19 within the last four days? _____ **Yes** _____ **No**

I confirm that I am not presenting with any of the following symptoms listed here:

• Fever • Shortness of breath • Dry cough • Runny nose • Sore throat ______________ (Initials)

I understand that air travel as well as other forms of mass transit significantly increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have not traveled by commercial airline, bus, or train within the past 14 days. ________________ (Initials)

____ ________________

Name – Signature Date