Gilbart Dental Care of Hagerstown
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Hello, and welcome to Gilbart Dental Care!

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care at reasonable prices, and proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

Your first appointment will take approximately 1 hour. To facilitate being seen just as soon as possible at the time of your appointment, we would appreciate it if you would complete the attached Patient Information and Medical / Dental History Forms before your arrival. Please remember to bring them with you at the time of your appointment.

We have reserved your appointment date and time specifically for you, so if you are unable to make the appointment with us, please notify us at least 48 hours in advance, so that we may give another patient the opportunity to use your appointment time instead.

We look forward to meeting you and serving your needs. Thanks again for choosing our dental practice.

Sincerely,

The Gilbart Dental Care Team

P.S. Remember to bring a photo ID (such as your driver's license), as well as any dental insurance cards that might apply to you or your family when you come in. And one more thing… please don't hesitate to call us anytime if we can help you in any way!

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Patient Name: _____ Prefers to be Called By: _____
Title First MI Last

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Address: _____
Street Apt. # City State Zip Code

Home Phone: _____ Work Phone: _____ Work Extension: _____

Mobile Phone: _____ Other Phone: _____ Best Time to Call: _____

Social Security #: _____ Date of Birth: _____ E-mail Address: _____

Employer Name: _____ Occupation: _____

In case of emergency, contact: _____ Phone: _____ Relationship: _____

Is another member of your family a patient at our office? Name: _____ Relationship: _____

Responsible Party Information (If Other Than Patient)

Name: _____ _____ Relationship to Patient: _____
Title First MI Last Signature of Responsible Party

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Address: _____
Street Apt. # City State Zip Code

Phone (H): _____ (W): _____ Ext: _____ Best Time to Call: _____

Social Security #: _____ Date of Birth: _____ E-mail Address: _____

Insurance Information

Name of Insured: _____ Is insured the patient? ☐ Yes ☐ No
Title First MI Last

If not, patient's relationship to insured: ☐ Spouse ☐ Child ☐ Other: _____

Insured's Date of Birth: _____ ID # / SS #: _____ Group #: _____

Insured's Address: _____
Street Apt. # City State Zip Code

Insured's Employer Name: _____ Occupation: _____

Employer's Address: _____
Street Apt. # City State Zip Code

Insurance Plan Name: _____ Phone: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient (friend) ☐ Another patient (relative)

☐ Dental Office ☐ Website ☐ Postcard ☐ Letter ☐ Work/Co-Worker ☐ Other: _____

Name of person/office/co-worker/website referring you to our practice: _____

Dental History

Patient Name: _____
Title First Middle Last

Reason for Today's Visit: _____

Date of last dental care: _____ Date of last dental x-rays: _____

Check (✓) if you have had problems with any of the following:

☐ Snoring	☐ Lack of energy / daytime sleepiness	☐ CPAP / BiPAP use
☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Do you have an oral appliance for teeth grinding? ☐ Yes--Upper Jaw ☐ Yes--Lower Jaw ☐ No

If so, how often do you wear it? ☐ Every night ☐ A few times/week ☐ A few times/month ☐ Never

If you have any OTHER kind of oral appliance, what is it and what is it for? _____

Medical History

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ AIDS	☐ Cortisone Treatments	☐ HIV Positive	☐ Skin Rash
☐ Anemia	☐ Cough, Persistent	☐ Jaw Pain	☐ Sleep Apnea
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ Kidney Disease	☐ Stroke
☐ Artificial Heart Valves	☐ Diabetes	☐ Liver Disease	☐ Swelling of Feet / Ankles
☐ Artificial Joints	☐ Epilepsy	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Asthma	☐ Fainting	☐ Nervous Problems	☐ Tobacco Habit
☐ Back Problems	☐ Glaucoma	☐ Pacemaker	☐ Tonsillitis
☐ Blood Disease	☐ Headaches	☐ Psychiatric Care	☐ Tuberculosis
☐ Cancer	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Chemical Dependency	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Chemotherapy	☐ Hemophilia	☐ Rheumatic Fever	
☐ Cholesterol (High)	☐ Hepatitis	☐ Scarlet Fever	
☐ Circulatory Problems	☐ High Blood Pressure	☐ Shortness of Breath	

OTHER PROBLEMS NOT LISTED ABOVE: _____

CURRENT MEDICATIONS: _____

ALLERGIES: _____

DOCTOR'S COMMENTS: _____
Signature of Doctor Date

Consent for Services

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due in full at the time of service. Outstanding balances are subject to an 18% APR (1.5% monthly) and a $10 monthly late fee. I understand that I will have to pay for any and all court and attorney fees that result from a court case arising from my failure to pay for dental services in a timely manner, as determined by this dental office. I further understand that a broken appointment fee will apply if I fail to give 48-hours advance notice to reschedule an appointment for my dependents or myself.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all services, whether the insurance plan pays for them or not. As a courtesy, this office will provide an insurance claim form for each patient. The patient can then submit this form to his/her dental insurance company for reimbursement according to the terms of their contract. If the dental office decides to accept assignment of benefits, then I authorize payment for all covered services to be made directly to the provider or the provider's designees with the notation "SIGNATURE ON FILE." Finally, I consent to the release of any information to the insurance company, payors, and/or their authorized representatives, as needed for processing my dental claims.

I understand that the treatment plan and associated fees are only an estimate and are subject to change depending upon individual circumstances. Due to the progressive nature of dental disease, a new examination and treatment plan may be needed after a period of twelve months from the date of the original patient examination. Also, fee estimates are only valid for 12-months from the exam date.

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. For example, while very rare, anaphylactic shock or permanent numbness is a possible complication after certain injections. I understand that I can ask for a complete recital of any possible complications.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian