GUNNERSON DENTAL

Patient Info:

Name_____ Preferred Name_____
Last First M

Birth Date ____/____/____ Email Address:_____

Address _____
Street Apt# City State Zip

Telephone Contact Information: Home (____)_____-_____Work (____)_____-_____ Cell (____)_____-_____

Place of Employment _____ Social Security # _____

Has any member of your family ever been treated in our office? Y N Name:_____

How did you hear about our office?_____

Whom may we thank for referring you to our office?_____

Insurance Info:

Dental Insurance Co. _____ ID/SS # _____

Name of Policy Holder _____ Birth Date ___/___/___ Employer_____

Medical:

Medical Insurance Co. _____ID/SS#_____

Name of Policy Holder_____ Birth Date___/___/___ Employer _____

Family Info:

Circle one: Father/Spouse

_____
Last First M

_____
Street City State Zip

_____
Home Phone# Cell#

_____
Employer

Circle one: Mother/Spouse

_____
Last First M

_____
Street City State Zip

_____
Home Phone# Cell#

_____
Employer

Person to Contact in Case of Emergency (outside of immediate family/household)

Name_____ Relationship_____ Phone (____)____-_____

Address _____City/State/Zip_____

Person Responsible for Account (Only if patient is a minor and responsible party must be present to sign)

Name_____ Birth Date ____/____/____
Last First M

Address _____
Street Apt# City State Zip

Contact Info: Home(____)____-_____Work(____)____-_____Cell(____)____-_____Email:_____

Employer _____SS#_____

Patient_____ Parent _____ Guardian_____ Signature _____

Initial_____

Office Policy and Federal Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Financial Policy

Patients who carry dental insurance understand that your policy is a contract between you, your employer and the insurance carrier and that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. In some cases we are a "Contracted Provider" which means that we agree to certain fees and terms that your insurance company has presented to us. Our office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. Dental insurance plans pay only a portion of your treatment and this dental office cannot render services on the assumption that our charges will be paid in full by any insurance company. We urge you to be fully aware of the provisions of your dental policy. We will obtain a basic overview of your insurance coverage in order to provide you with an estimate of how your insurance may pay toward your needed dental services. Insurance carriers do not guarantee the information they give over the telephone as dental insurance policies are ever changing. We will do our best to estimate your coverage in good faith, however we cannot guarantee that the estimate is exactly how your insurance will pay on your behalf. Many insurance carriers will only pay towards the lowest treatment that would restore a tooth. This is often not the best long-term restoration option. Pre-determinations for primary insurance contributions can be filed at the patient's request before treatment begins if it is allowed through your specific insurance. Please be aware that some, and perhaps all, of the services provided may be non-covered services under the terms of your specific insurance policy. This does not mean treatment was inappropriate or unnecessary. It means that the contract set up between you (or your employer) and the insurance company has chosen not to contribute towards those procedures. Our practice is committed to providing the best treatment for our patients and we charge the average fees for our area. We routinely evaluate and check our fees to provide the lowest reasonable costs for our patients. All fees or co-pays will be due and payable at the time treatment is rendered unless prior arrangements have been made.

A service charge of 1.5% per month (18% per annum) or the interest % allowable by law; or a minimum charge of up to $5.00 per month on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I will pay a service charge of $35.00 for all returned checks (or the amount specified by law). I understand that the fee estimate listed for dental care can only be extended for a period of six (6) months from the date of the patient examination or treatment has been proposed.

In consideration for the professional services rendered to me (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by Gunnerson Dental. Should my account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the collection agency or attorney should collection procedures as described become necessary.

Methods of Payment

We accept cash, check, Care Credit and major credit cards. Patients using outside financing companies are responsible for understanding the payment terms associated with those companies.

Initial_____

Minors

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. Unaccompanied minors will need to bring payment with them, or the parent may call and pay over the phone with a credit card at the time of the appointment.

Changing Reservations

Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. Although this office makes an effort to contact patients ahead of time to confirm their appointments, this is not always possible and we expect our patients to remember the time set aside for them in this office. If you must change your appointment we require at least 48 hours notice, outside of emergencies. We reserve the right to charge a missed appointment charge of up to $50 per half hour of scheduled time.

Transferring Records

In order to have records transferred for any reason, a request in writing must be received by Gunnerson Dental. Allow at least thirty days in order to research and send the required documents. There may be a cost to print and send your records. In the occurrence that there is a cost, payment i required before documents can be transferred. There will be no cost for record copies if we are referring you to a specialist.

Contact Methods

I grant permission to you or your assignee to telephone me at home, my workplace, on a cell phone via phone or texting or via email by first and/or third party to discuss matters related to this form or my account. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

Photo and Digital Image Consent

I grant permission for Gunnerson Dental and its employees to take pictures of my teeth, smile or entire face. These photos may be used for insurance and liability reasons. Some dental cases are unique and may be helpful for other patients to make a decision regarding dental treatment. These photos and digital images may be used free of charge for internal office use, internet, and for educational purposes. I may revoke permission to continue using my photos/images time by contacting Gunnerson Dental in writing. I understand that my photos/images will not be identified with my name when used for purposes other than my personal treatment.

Acknowledgements

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received and/or been given the opportunity to read a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I hereby agree to abide by the conditions outlined herein.

I hereby certify that the answers on my personal and medical history are accurate to the best of my ability. Since a change in my medical condition or in medications I take can affect the dental treatment, I understand the importance of and agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

Signature of Patient or Legal Guardian _____ Date: _____

Name (please print) _____

Signature of Witness:_____ Date:_____

Name (please print) _____

Consent to Proceed

I authorize Dr. Gunnerson and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effect which may include but are not limited to; bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of any foregoing procedures have been or will be explained to me if necessary prior to proceeding with treatment and I have been or will be given the opportunity to ask questions.

Print Patient Name: _____ Date of Birth: ____/_____/_____

Signature: _____Date: _____/_____/_____

(Patient, legal guardian or authorized agent of patient)

Office Witness: _____ Date: _____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, (print name) _____, have had an opportunity to read this office's Notice of Privacy Practices. I have also received this notice on behalf of my minor children listed below if applicable.

_____ _____

_____ _____

_____ _____

_____ _____

I authorize Gunnerson Dental to discuss my (and the minor children listed above) appointments, treatment, and financial information (including insurance information regarding coverage, payments etc.) relating to my account with the following individuals until permission is revoked in writing.

Please print information legibly

_____	_____	_____
Name	Phone #	Date of Birth
_____	_____	_____
Name	Phone #	Date of Birth
_____	_____	_____
Name	Phone #	Date of Birth

_____ _____

Patient Signature Date

Office Use Only: Individual Signed_____ Individual refused to sign_____ Language barrier prohibited obtaining the acknowledgement_____ An emergency situation prevented us from obtaining acknowledgement_____ Other_____

Witness Signature & printed name_____ Date:_____