Patient Information

Name ______________________ DOB ______-______-______ SS# ______________________

Address ______________________ City ______________________ ST __________ Zip ____________

Email ______________________ Home Phone ______________________ Cell Phone ______________________

How did you hear about our office? ____

Patient Medical History

Do you have history of:	Y	N		Y	N		Y	N
Heart Disease			Diabetes			Cancer		
Heart Murmur			Arthritis			Osteoporosis		
Rheumatic Fever			Anemia			HIV/Aids		
Mitral Valve Prolapse			Thyroid Disease			Ulcers/Stomach Problems		
Pace Maker			Lung Disease			Cholesterol		
Stroke			Liver Disease			Sinus Problems		
High Blood Pressure			Hepatitis A,B,C			Drug Addiction/Alcoholism		
Low Blood Pressure			Kidney Disease			Other:		
Aspirin Therapy			Epilepsy/ Seizures					

Are you pregnant? ______________________
Do you snore? ______________________
Do you clench your teeth? ______________________
Are your teeth sensitive? ______________________
Are you interested in teeth whitening? __________
Are you on blood thinners? ______________________

Do you have any artificial joints or stints? ______________
Do you have headaches/ migraines? ______________
Have you had orthodontics? ______________________
Have you been diagnosed with sleep apnea? ____________
Do you smoke or use tobacco? ______________________
Have you ever had a reaction to anesthetics? ____________

Due to osteoporosis or cancer, are you taking or have taken Oral Bisphosphonate, e.g., **FOSAMAX, ACTONEL, BONIVA, RECLAST** or **IV Bisphosphonate**, e.g.; **ZOMETA, AREDIA, etc.?** If yes, how long? ______________________

List any medications you are allergic to: ____

List any medications you are taking or provide a copy of the list of medications: ______________________

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Patients Signature ______________________ Doctors Signature ______________________

UNDERSTANDING AND AGREEMENTS

(Signature Required)

In an effort to assist our patients with their Dental Insurance, we at Gateway Dental are asking you to be your own advocate. It is beyond our control to know everything there is to know about each patient's insurance policy. We do our best to determine benefits, file insurance and to schedule patients based on those benefits. However if you will be aware of your benefits, *(i.e. knowing your maximum, when policy renews, how much you have used, how often you may have had preventive treatments.)* we will be able to help you maximize your insurance.

I understand that I must read this understanding agreements section and sign that I have read it before any treatment will be provided. I understand that nothing is perfect and nothing is permanent. I realize that my own God-given teeth can decay, chip, crack, break or otherwise fail, and despite the best efforts of the doctor, the staff and lab technicians, and our man-made materials, results cannot be guaranteed or predicted with certainty. I understand that the doctor cannot always provide what I desire or what I feel like I deserve. I understand that any warranties on dental materials or procedures are contingent upon keeping regularly scheduled appointments for cleaning, scaling and follow-up visits at this office. ***Payment Policy of this office is as follows***, we ask that all patients pay any charges, deductibles and or percentages at the time services are rendered. Your agreement with your insurance company is between the two of you and not you and this office. We do file insurance as a courtesy to our patients. ***You are the responsible party for all charges incurred at this office.***

Cell Phone:

- I consent to the dental practice using my cell phone number to Call or Text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.
- My cell phone number is ______________________________ Initials ________

Thank you,

Dr. Patricia Calabria

Dr. Andre Ellis

Signature ______________________________

Date ______________________________

Authorization to Disclose Protected Health Information

Name: ________________________________ DOB: ____________________________

Address: ______________________City ________________ ST: ________Zip: __________

Home Phone: __________________________ Cell Phone: ____________________________

Email: ____

I Authorize the Following to Disclose the Individual's Health Information

Gateway Dental
4013 Gateway Dr.
Colleyville, TX 76034
Phone: (817) 858-6333 Fax: (817) 868-0068

Who Can Receive and use health information

Name: ________________________________ Relationship: _____________________

Name: ________________________________ Relationship: _____________________

Name: ________________________________ Relationship: _____________________

Effective Time Period: This authorization is valid until the earlier of the occurrence of death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date: __________

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person named under "Who can receive and use health information" I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature of Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by my Texas Health & Safety Code. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature: ____________________________________ Date: _______________