GUNN FAMILY DENTISTRY
911 Hal Greer Blvd, Huntington, WV 25701 – (304)523-1245 **www.gunndental.com**

PATIENT REGISTRATION

Date: _____

PATIENT INFORMATION - All areas **MUST** be filled out **COMPLETELY**

Name _____ Date of Birth:_____ Age:_____ Gender: ☐ Male ☐ Female

Last First MI

Address: _____ City/State/Zip: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____ Email: _____ Marital Status: _____

Level of Education: _____ Student Status if over 19 (for Ins.) ☐ Non-student ☐ Full-time ☐ Part-time

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Other: _____ Occupation: _____

Employer: _____ Employer's Address: _____ Work Phone:_____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone/Text Message ☐ Email

Nearest relative in area: _____ Address: _____ Phone: _____

Spouse's Name: _____ Phone: _____ Social Security #: _____

Who can we thank for referring you to this office? _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian
☐ Other Pacific Islander ☐ White/Caucasian ☐ Other Race_____ ☐ Unreported/Refused to Report

Ethnicity: Do you consider yourself to be Hispanic or Latino? ☐ Yes, I am ☐ No, I am not ☐ Unreported/Refused to Report

Preferred Language: ☐ English ☐ Spanish ☐ Arabic ☐ Chinese ☐ Italian ☐ French Other: _____

INSURANCE AND PAYMENT

IDIVIDUAL RESPONSIBLE FOR PAYMENT

Name: _____ Relationship _____ Social Security #: _____

Address: _____ City/State/Zip:_____ Phone: _____

Occupation: _____ Employer: _____ Employer's Address: _____

Driver's license No: _____ State: _____ Expiration date: _____ Email: _____

Bill will be paid by: ☐ Self ☐ Insurance ☐ Other – Who? _____

INSURANCE INFORMATION (Please present Insurance Card and ID to receptionist)

Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Policy #: _____ Eligibility Dates: _____

Insurance Company: _____ Phone: _____ Medicaid #: _____

ACKNOWLEDGMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, nurse or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay to them in full AT TIME OF SERVICE.

Signed X _____

PATIENT, PARENT OR AGENT (MUST BE 18 YEARS OF AGE OR OLDER)

PLEASE READ AND COMPLETE THE NEXT PAGE

Patient's Name: _____ Date of Birth: _____

MEDICAL & DENTAL HISTORY - All areas **MUST** be filled out **COMPLETELY**

Family Doctor/Physician's Name: _____ Address/City/State: _____
Phone:_____

When did you last consult a physician? _____ Reason: _____

Have you been a patient in a hospital in the past 5 yrs? ☐ Yes ☐ No If so, why?_____

Have you had any serious illnesses or operations? ☐ Yes ☐ No ☐ If so, when? _____

Name of Former Dentist: _____ Address: _____ Phone: _____
When did you last visit a dentist? _____ Purpose of visit: _____

Purpose of today's visit: ☐ Complete examination ☐ Pain ☐ Broken tooth ☐ Other: _____

Are you satisfied with your smile? ☐ Yes ☐ No If not, what changes would you like to see? _____

PLEASE MARK INDIVIDUALLY WITH AN [X] AND DESCRIBE FULLY ON REMARKS IF YOU HAVE/HAD THE FOLLOWING:

- ☐ Heart Problems
- ☐ Congenital Heart Defect
- ☐ Bacterial Endocarditis
- ☐ Prosthetic Heart Valve
- ☐ Heart Attack……If so, when?_____
- ☐ Heart Transplant
- ☐ Pacemaker Circle
- ☐ Blood Pressure Problems (low/high)
- ☐ Blood Disorder – Anemia
- ☐ Hemophilia (excessive bleeding)
- ☐ Thyroid Disease
- ☐ Diabetes (Type I/Type II)
- ☐ Stroke…….... If so, when?_____
- ☐ Epilepsy
- ☐ Psychiatric Treatment/Emotional Problems
- ☐ Depression/Anxiety (Circle)
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Cancer (Type:_____)
- ☐ Venereal Disease Circle
- ☐ Sinus Trouble/Hay Fever (Acute/Chronic)
- ☐ Stomach Ulcers
- ☐ Radiation Treatment Location:_____
- ☐ Liver Disease
- ☐ Hepatitis - Type:_____
- ☐ Jaundice
- ☐ Asthma
- ☐ Emphysema/Respiratory Problems
- ☐ Tuberculosis
- ☐ Chronic Coughing
- ☐ Artificial Joints/Hip, Prosthetics
- ☐ HIV/AIDS Circle
- ☐ Major Weight Change (Increase/Decrease)
- ☐ Turned Down as a Blood Donor
  If yes, Why? _____

Allergies:
- ☐ Penicillin
- ☐ Other antibiotics _____
- ☐ Codeine
- ☐ Aspirin
- ☐ Local Anesthetic, Novocain
- ☐ Others (please explain)…..……

Are you taking ANY medication, drugs or pills? ☐ Yes ☐ No

List all the medications or drugs you are now taking: _____

_____

Have you had excessive bleeding requiring treatment? ☐ Yes ☐ No

Have you experienced any unfavorable reaction to previous dental treatment? ☐ Yes (Explain in "Remarks") ☐ No

Are you pregnant (Female)? ☐ Yes ☐ No

Do you smoke or use chewing tobacco? ☐ Yes ☐ No If Yes, what kind and How much? _____

Are you interested in quitting the use of tobacco? ☐ Yes ☐ No

Do you have any disease or problem not listed above that you think I should know about? ☐ Yes ☐ No

REMARKS: _____

_____

Patient's Signature (Guardian)X _____ Date _____

FINANCIAL POLICY AND AGREEMENT

Payment for treatment is due at the time services are rendered. **We accept cash, checks, money order, MasterCard, Visa, Discover and American Express**. We accept most insurance. If you have dental insurance, you should bring in your dental insurance card at each visit.

1. Patients with insurance: In our office, we strive to maximize your insurance benefits and submit the claims necessary so you receive the full benefits of your coverage. However, we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Insurance policies vary considerably; therefore, we try to estimate your coverage in good faith. The Patient/Responsible Party is responsible for the estimated non-covered portion, procedures, co-insurance and deductibles at the time of the service. It is the Patient/Responsible Party's responsibility to pay any other balance not paid by the insurance company. It is also the patient's responsibility to understand his/her policy and its benefits. ***If the insurance company has not made payment within 60 days of billing, the balance will become the patient's responsibility. It is the patient's responsibility to provide Gunn Family Dentistry with correct insurance information***. If the patient provides wrong insurance information, it is the patient's responsibility to pay his/her balances in full. Gunn Family Dentistry will not enter into a dispute with your insurance company over any claim.

2. **Guardians/Parents accompanying their children** are financially responsible for payment.

3. Patients without insurance: The Patient/Responsible Party is responsible for making full payment for treatment at the time services are rendered.

4. Patients with outstanding balance: The Patient/Responsible party will receive a statement each month. If your account is over 90 days, it will be subject to our collection agency.

5. There will be a $25.00 charge for all returned checks.

In the event legal action should become necessary to collect an unpaid balance for dental services rendered to you or your family, you agree to pay attorney's fees or other such costs as the court determines proper.

I will be paying for services today by:

☐ Cash ☐ Check ☐ Credit/Debit Card ☐ WV Medicaid ☐ Dental Insurance _____

The estimated portion which is not covered by insurance or Medicaid will be paid today by:

☐ Cash ☐ Check ☐ Credit/Debit Card

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I acknowledge I have read all the above information and agree to its terms.

Signed X_____ Date: _____

Responsible Party X _____ Date: _____

ATTENTION ALL PATIENTS

Broken Appointment Policy: I understand that if I fail to keep a scheduled appointment without giving **24 hours notice**, I will be responsible and may be charged a broken appointment fee of **$20.00. I know that after a certain number of infractions, I will be dismissed from the practice.** (*If any questions, please ask receptionist for full disclosure of policy.)*

Patient's Signature X _____