Welcome!

Thank you for choosing DOCTORS' GIBSON, RENFROE, ZIEMAN, AND HEATH.

Please, fill out this form as completely as you can. If you have any questions, we will be happy to help. (Please print)

PATIENT INFORMATION

Name ____ ( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Rev. ( ) Other
First MI Last

Address____ City ____________________________State _____ Zip_________

Home Phone # (____) _____________________ Cell Phone # (____) ____________________

( ) Male ( ) Female Are you: ( ) Minor ( ) Married ( ) Single ( ) Divorced ( ) Widowed ( ) Separated

DOB: _____/_____/______ SSN # __________________________ E-mail_________________________@_____________________

Occupation____________________ Employer__________________________________ Wk # (____) __________________ Ext ______

Spouse's Name ____ Cell Phone # (____) __________________
First MI Last (if different)

Spouse occupation____ Wk # (____) ____________________ Ext ________

Is patient a full time student? ( ) No ( )Yes: Name of school: ____

RESPONSIBLE PARTY (if different than patient)	**Whom may we thank for referring you?**
Name ____ First MI Last Address____ City ____________________________State _____Zip______ Hm # (___)____ Wk # (___)_______________________________ DOB: ___/____/______ SSN # ______________________________ Relationship_________________________	____ **YOUR PREFERENCES** (How would you like to be contacted?) Do you prefer appointment reminders by: ( ) Email ( ) Phone ( ) Text Do you prefer to receive calls from our office at: ( ) Home ( ) Work ( ) Cell How do you wish to be addressed by our staff? ____

INSURANCE INFORMATION

Dental Insurance:

Insured Name/Subscriber ____Relationship to patient: __________________________

Address: ____City_____________________________St. ____ Zip___________

DOB:___/___/____ SSN # ________________________ Employer: ____

Insurance Company_________________________________ Group # __________________________ Eff. Date: _____/_____/______

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ( ) Yes ( ) No If yes, please complete the following:

Insured Name/Subscriber ____Relationship to patient: ___________________________

Address _______________________________________ City ________________________State ____Zip________

DOB: _____/_____/______ SSN #_____________________________ Employer: ____

Insurance Company ___________________________ Group# __________________________ Eff. Date: _____/_____/______*

**** Please present copy of insurance card***

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MEDICAL HISTORY

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Do you have, or have you had any of the following? ***(Circle Y if you have or have had.)***

Acid Reflux	Y
ADHD	Y
AIDS/HIV Positive	Y
Alzheimer's Disease	Y
Anaphylaxis	Y
Anemia	Y
Angina	Y
Anxiety	Y
Arthritis/Gout	Y
Artificial Heart Valve	Y
Artificial Joint	Y
Asthma	Y
Blood Disease	Y
Breathing Problems	Y
Cancer Affected Area ____________	Y
Chemotherapy	Y
Chest Pains	Y
Cold sores/Fever Blisters	Y
Depression	Y
Diabetes	Y
Drug Addition	Y
Eating Disorders	Y
Emphysema	Y
Epilepsy or Seizures	Y
Excessive Bleeding	Y
Fainting Spells/Dizziness	Y
Fibromyalgia	Y
Glaucoma	Y
Heart Attack/Failure	Y
Heart Murmur	Y
Heart Surgery	Y
Heart Pacemaker	Y
Heart Disease	Y
Hepatitis - Type ____	Y
Herpes	Y
High Blood Pressure	Y
High Cholesterol	Y

Kidney Problems	Y
Leukemia	Y
Liver Disease	Y
Lung Disease	Y
Lupus	Y
Mental Disorder	Y
Mitral Valve Prolapse	Y
Osteoporosis	Y
Psychiatric Care	Y
Radiation Treatments	Y
Renal Dialysis	Y
Respiratory Problem	Y
Rheumatic Fever	Y
Rheumatism	Y
Sinus Trouble	Y
Soft or Special Diet	Y
Stomach/Intestinal Disease	Y
Stroke	Y
Swelling of Limbs	Y
Thyroid Disease	Y
Tumors or Growths	Y
Ulcers	Y
Venereal Disease	Y

List other known allergies:
1
2
3
4
5
6

Do you take or need antibiotics before dental procedures?	Y

Premedication/s needed:
1
2

Oral	
Bleeding gums	Y
Dry mouth	Y
Jaw Problems (TMJ)	Y
Clicking?	
Pain?	Y
Difficulty swallowing?	Y
Difficulty chewing?	Y
Difficulty opening/closing?	Y
Orthodontics/Invisalign	Y
Periodontal Disease	Y
Periodontal Treatment	Y
Teeth Grinding/Clenching	Y
Bite Plate or Mouth Guard	Y
Serious injury to mouth or head	Y
Tooth Pain	Y
Sleep	
Daytime Sleepiness	Y
Morning headaches	Y
Obstructive Sleep Apnea	Y
Do you use a CPAP? How often? __________	Y
Has anyone told you that you snore?	Y

Social History	
Do you smoke? _____ packs per day	Y
Do you use smokeless tobacco?	Y
Do you consume alcoholic beverages? ____ drinks per day/week/month	Y
Do you use recreational drugs?	Y

Have you taken any Bisphosphonate drugs for Osteoporosis such as Fosamax, Actonel, Boniva, or other?	Y
Have you taken any blood thinning medications such as Plavix, Coumadin, Warfarin, or other?	Y

Women, are you:
Pregnant ( ) Nursing ( ) Taking oral contraceptives ( ) IUD's ( ) Trying to get pregnant ( )

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MEDICAL HISTORY (continued)

List any medications you are taking:

Medication **Reason** **Prescribing Physician**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

List any surgeries or hospitalizations you have had:

Date (year) **Surgery** **Surgeon** **Reason**

1. ____
2. ____
3. ____
4. ____
5. ____

List and detail any medical condition or history not listed above:

____

____

____

Primary Physician's Name: _________________________________**Physician's phone #:** (____) ___________________

Are you under the care of other physicians? If so, please list:

Physician Name	Physician Phone #	Reason
	( )	
	( )	
	( )	
	( )	

CONSENT

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Gibson, Renfroe, Zieman, and Heath Family Dentistry to take radiographs, study models, photographs, or other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Gibson, Renfroe, Zieman, and Heath Family Dentistry try to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Gibson, Renfroe, Zieman, and Heath Family Dentistry choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Gibson, Renfroe, Zieman, and Heath Family Dentistry. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental insurance (if any). I further consent to and agree to pay a 1 ½% finance Charge (18% annually) that will be applied to any balance over 60 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Gibson, Renfroe, Zieman, and Heath Family Dentistry and staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult):
Name of Patient ____

____ Date ______________
Signature of patient

Consent (for a minor child):
Name of Parent/Guardian ____

____ Date _________________
Signature of Parent/Guardian

Notice of Privacy Practices below)
Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release if pertinent medical records to my insurance company (if applicable) and my other medical providers.

____ Date ______________________

Signature of Patient

Gibson, Renfroe, Zieman, and Heath Family Dentistry
13 Center Street Gulf Breeze, Fl 32561
(850)932-2266

Cancellation Policy

This policy is frequently reviewed by our staff to ensure proper patient care, improve office efficiency and make patients visits as smooth and enjoyable as possible. Gibson, Renfroe, Zieman, and Heath dental care is commonly scheduled weeks to months in advance for treatment and cleaning appointments. Failure to keep an appointment could push your treatment back a significant amount of time. Also, failed appointments or short notice cancellations don't allow enough time to fill the scheduled time, preventing other patients' needs unserved.

Patients must inform our office staff of any appointment changes prior to 24 hours of appointment time in order to prevent documentation of a short notice cancellation alert on account. Any appointments that are cancelled within 24 hours of the appointment will be documented and patients may be required to provide a credit card number to reserve future appointment time.

Our office may refuse to schedule multiple family members for treatment on the same date of service if a history develops of short notice cancellations or failed appointments.

Same day appointment cancellations or no shows will be documented in the patient account as a failed appointment and patients will be required to prepay for any future appointments and may be charged **$60.00** per appointment cancellation fee.

Patient Signature ____ **Date:** ______________

Print Name: ____