GERALD A. CLARK DDS
DENTISTRY

Today's Date: _____

General Information

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws.

First name _____ Middle name _____ Last name _____

Nickname/Preferred name _____ Patient DOB _____ Social Security # _____

Email _____ Gender ☐ Male ☐ Female Marital Status _____

Contact Information

Home # _____ Work # _____ Mobile # _____

Address _____ City _____ State _____ Zip code _____

Emergency contact _____ Relationship _____ Phone # _____

Family doctor _____ Family doctor # _____

Preferred Pharmacy _____ Preferred Pharmacy # _____

Occupation _____ Employer _____

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Conditions

Check all that apply:

- ☐ Abnormal/excessive bleeding
- ☐ AIDS/HIV
- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Blood thinners
- ☐ Breathing problems
- ☐ Bronchitis
- ☐ Cancer/Chemo/Radiation
- ☐ Cardiovascular disease
- ☐ Chronic pain
- ☐ Congestive heart failure
- ☐ Damaged heart valves
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Fear of needles
- ☐ Frequent headaches
- ☐ GERD/Heartburn
- ☐ Glaucoma
- ☐ Gout
- ☐ Hearing difficulties
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart rhythm disorder
- ☐ Hepatitis Type? _____
- ☐ Herpes
- ☐ High blood pressure
- ☐ Jaundice or liver disease
- ☐ Joint replacement
- ☐ Kidney disease
- ☐ Kidney problems
- ☐ Low blood pressure
- ☐ Low pain tolerance
- ☐ Medications
- ☐ Mitral valve prolapse
- ☐ Neurological disorders
- ☐ Night sweats
- ☐ Osteoporosis
- ☐ Pace maker
- ☐ Persistent swollen glands in neck
- ☐ Pre medicate
- ☐ Pregnant
- ☐ Psychiatric care
- ☐ Recurrent infections
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Rheumatism
- ☐ Rheumatoid arthritis
- ☐ Severe headaches/migraines
- ☐ Severe or rapid weight loss
- ☐ Sexually transmitted disease
- ☐ Sinus trouble
- ☐ Stroke
- ☐ Thyroid problems
- ☐ TMJ disorder
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers

_____

- ☐ Do you have issues with severe coughing?
- ☐ Do you drink alcoholic beverages?
- ☐ Are you taking any over the counter medications?
- ☐ Are you pregnant?
- ☐ Are you nursing?
- ☐ Have you had an orthopedic total joint replacement?
- ☐ Do you use tobacco?
- ☐ Are you wearing a nicotine patch?
- ☐ Do you have sleep apnea?

I attest to the accuracy and completeness of the information that I provided is to the best of my knowledge.

Sign: _____ Date: _____

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Dental Information

Check all that apply:

- ☐ Do your gums bleed when you floss?
- ☐ Are your teeth sensitive to cold, hot, sweets, or pressure?
- ☐ Does food or floss catch between your teeth?
- ☐ Have you had any periodontal (gum) treatment?
- ☐ Have you ever had orthodontic treatment?
- ☐ Have you had any problems associated with previous dental treatment?
- ☐ Do you drink bottled water?
- ☐ Do you drink tap water?
- ☐ Are you currently experience dental pain or discomfort?
- ☐ Do you have earaches or neck pains?
- ☐ Do you have any clicking, popping or discomfort in your jaw?
- ☐ Do you grind your teeth?
- ☐ Do you have any sores or ulcers in your mouth?
- ☐ Do you wear partial dentures or full dentures?
- ☐ Have you ever had a serious injury to your head, neck or mouth?

- ☐ Would you like whiter teeth?
- ☐ Would you like straighter teeth?
- ☐ Would you like a more confident smile?

Allergies

- ☐ Acetaminophen/Tylenol
- ☐ Acrylic
- ☐ Animals
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Erythromycin
- ☐ Food
- ☐ Hay fever/seasonal
- ☐ Ibuprofen/Motrin/Advil
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetic
- ☐ Metals
- ☐ Morphine
- ☐ Penicillin's
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Others: _____

List of medications: _____

_____

_____

_____

_____

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Patient Financial Agreement

Patient Name: _____ Date: _____

Gerald A Clark, DDS, Incorporated is committed to providing quality care at an affordable cost. In order to keep this commitment, we ask that all financial obligations and payments be taken care of at the time of service. Unless other arrangements have been made in advanced, payment is due at the time of service. For your convenience, we accept cash, checks, money orders, VISA, MasterCard, Discover, and American Express. We will also accept payment through CareCredit® and iCare Financial. As a courtesy to you, we will file all insurance claims with your dental insurance. However, it is your sole responsibility to provide us with the accurate and complete information for your primary and secondary insurance. If needed, we will contact your dental insurance to obtain an estimate of your benefits. Please understand that the fee you will be asked to pay is only an estimate based on your insurance. It is not a guarantee of insurance payment. Ultimately, you are responsible for any and all balances not covered by your insurance.

I authorize the release of any medical, dental, or other information necessary to process any and all insurance claims filed by Gerald A Clark, DDS, Incorporated.

I authorized and request payment of all medical and dental benefits made on my behalf to be paid directly to Gerald A Clark, DDS, Incorporated.

I understand that if I do not provide accurate and correct insurance information at the time of service, I will be responsible for the total amount of the services provided to me.

I understand that in-network or plan participation does not guarantee coverage and that coverage and actual responsibility can only be determined once your insurance claim is filed.

I understand that my insurance may not agree to the UCR charges for my area and that my benefits may not cover all services.

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I understand that my insurance could deny payment for services that have been previously determined or approved in advance. I further understand that if payment is denied for any reason, the remaining balance due is my responsibility.

I understand that insurance claims can take 30 to 120+ days to process and that all charges at the time of service become my responsibility, regardless of insurance status.

I have read and understand Gerald A Clark, DDS, Incorporated financial policies and I agree to be bound by its terms. I accept responsibility for the payment of any and all fees associated with my care that my insurance does not cover, including by not limited to deductible, coinsurance, co pays, and any and all other balances remaining after insurance.

I agree to immediately pay any and all balances remaining on my account after insurance has paid.

I understand that a $25.00 processing fee will be charged per returned check.

I understand that I may be required to hold a credit card on file for any balance not covered by my insurance.

Notice of Privacy Practices: I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me and a copy can be obtained at my request. I have been given the opportunity to ask any questions regarding office policy and practices. I have been advised that my care cannot be discussed with anyone without my permission.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Relationship: _____

Staff Witness Signature: _____