gordon DENTISTRY

Thank you for choosing Gordon Dentistry. We strive to provide you with the best possible dental care. To help us meet all your healthcare needs, please complete this form. If you have any questions or need assistance, please ask us -- we will be happy to help.

Date

Patient Information

Name (Last) (First) (M I) ◯ Male ◯ Female ◯ Married ◯ Single ◯ Other

Date of Birth SSN Email

Phone Work ext. Cell

Address City State Zip Code

How did you hear about Dr. Gordon?

Spouse or Responsible Party Information

Name (Last) (First) (M I) ◯ Patient's Spouse ◯ Person responsible for payment

◯ Male ◯ Female Date of Birth SSN Email

Phone Work ext. Cell

Address City State Zip Code

Employment Information

The following is for: ◯ Patient's Spouse ◯ Person responsible for payment

Employer Name Occupation

Address City State Zip Code

Insurance Information

PRIMARY

Name of Insured (Last) (First) (M I)

Insured's Date of Birth ID# Group#

Insured's Employer Name City

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan name and address

This space is for Secondary Insurance or additional information

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Name:

Patient Dental History

What do you like about your smile?

What do you dislike?

Reason for today's visit:

Former dentist: City/State

Date of last dental visit Date of last full-mouth Xrays

ORAL HEALTH — PLEASE CHECK ALL THAT APPLY

- ☐ Bad breath?
- ☐ Bleeding gums?
- ☐ Burning sensation on tongue?
- ☐ Chew on side of mouth?
- ☐ Cigarette, pipe or cigar smoking?
- ☐ Dry mouth?
- ☐ Food collection between teeth?
- ☐ Gums swollen or tender?
- ☐ Jaw pain or tiredness?
- ☐ Loose teeth or broken fillings?
- ☐ Sensitivity to sweets?
- ☐ Sensitivity when biting?
- ☐ Mouth breathing?
- ☐ Mouth pain when brushing?
- ☐ Orthodontic treatment?
  If yes, date:
- ☐ Periodontal treatment?
  If yes, date and duration of treatment:
- ☐ Pain around ear?
- ☐ Sensitivity to cold?
- ☐ Sensitivity to heat?
- ☐ Sores, herpes or growths in mouth?

☐ Have you ever had any complications or excessive bleeding following dental treatment?
If yes, explain:

☐ Did any previous dentist recommend dental treatment that was never performed?
If yes, what type or work and why was it not performed?

Consent for Services

I certify that I have read and understand the information contained in this document to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand that photographs, x-rays and other records may be made during the course of my examination, treatment and follow-up care. I give my permission for such items to be used for: ◯ *Purposes of diagnosis, research, education, publication in professional journals or to promote Gordon Dentistry* ◯ *Purposes of diagnosis only.*

Signature of patient, parent or guardian Date

Signature of guarantor of pmt/responsible party Date

Relationship to patient:

Doctor's Signature Date

Nicole T. Gordon, DMD

☐ I acknowledge that I was given a copy of the privacy notice.

☐ I acknowledge that I declined the copy of the privacy notice that was offered.

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Name:

Patient Health History

We will review this information with you at each visit. Please include current & past conditions

- ☐ Aids/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Allergies
- ☐ Artificial Heart Valves
- ☐ Artificial Joints (knee/hip)
- ☐ Asthma
- ☐ Blood Disease/Abnormal Bleeding
- ☐ Cancer or Tumors
- ☐ Chemotherapy
- ☐ Cortisone Treatments
- ☐ Diabetes
  Last AIC
- ☐ Dizziness
- ☐ Endocarditis
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Conditions
  Diagnosis
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date
- ☐ Pulmonary
  DS Type
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other

Name of Primary Physician

Phone

Please list all medications and herbal supplements

Allergies ☐ Penicillin ☐ Latex ☐ Other

Signature of patient, parent or guardian

Date