



Garrison Family Dentistry
Dr. Matthew Garrison

Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out these forms as complete as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Home Phone: _____ Today's Date: _____

Name: _____ Soc. Sec. # _____
Last First Initial

Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birthdate: _____ Single Married Widow Separated Divorced

Patient Employed By: _____ Occupation: _____

Business Phone: _____ Cell Phone: _____ email: _____

How did you find out about our office? _____

In case of emergency, who should be notified? _____

Person Responsible for the Account: _____
Last First Middle Initial

Address(if different than patient) _____

City: _____ State: _____ Zip: _____ Phone: _____

Primary Dental Insurance: Company Name: _____ Phone: _____

Subscriber ID#: _____ Group #: _____

Please let us know if you are covered by a secondary insurance company.

Medical History

Physician's Name: _____ Date of last visit: _____
Have you had any serious illness or operations? ___Yes ___No If yes, give approximate date: _____

Have you ever had a blood transfusion? ___Yes ___No If Yes, give approximate date: _____

(Women) Are you pregnant? ___Yes ___No Nursing? ___Yes ___No Taking birth control pills? ___Yes ___No

Check if you have or have had any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of feet/ankles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease | |

Please list any medications you are currently taking:

<u>Medicine:</u>	<u>dose:</u>	<u>Allergies to medication:</u>	<u>reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Authorization:

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that payment (or estimated insurance co-payment) is due in full at time of treatment unless prior arrangements have been approved by Dr. Garrison in writing. I further understand that I am fully financially responsible for any and all collection fees charged to Dr. Garrison should my account become past due and collection activities precede.

I authorize Dr. Garrison to take photographs for his use in seminars, patient education, laboratory communication, marketing, and post graduation education requirements.

If patient if a minor (under age 18), I agree that I am acting as minor's parent or legal guardian. I authorize Dr. Garrison or his staff to perform dental care for above mentioned minor using their professional judgment in my absence. I further understand that ultimately I am responsible for above minor's account, whether insurance contracts or divorce rulings state otherwise.

Signature: _____ **date:** _____



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What would you like us to do for you?

(mark all that apply)

- Help me keep my teeth for the rest of my life
- Help me improve my smile
- Examine my mouth and give me a report
- I want to prevent decay and toothaches
- I want fresher breath
- I want whiter teeth
- Stop my gums from bleeding
- Get me out of pain
- Fix the hole in my tooth
- Give me more teeth to chew with
- Remove my wisdom teeth
- Teach me how to care for my teeth

Comments: _____

All of the requests above are possible to achieve. They will require some work on our part and yours as well. We will try to create a plan for you that will meet the goals you have for your mouth. It may take some time, but when we are finished, you will have the satisfaction of knowing it was done right and that you know how to care for your mouth and protect your investment in good dental health.

Sincerely,

Dr. Matt Garrison and Staff

Dental History

Former dentist: _____ Address: _____

Reason for leaving former dentist: _____

Date of last dental care: _____ Date of last dental x-rays: _____

Check if you've had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in mouth |

How often do you floss? _____ How often do you brush? _____



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We strongly believe in our professional services. Please read this page thoroughly and then sign at the bottom to indicate that you understand our policies and agree to comply.

Commitment To Treatment

We believe that any and all treatment started should be completed. Incomplete treatment leads to problems, complications, misunderstandings, and usually further progression of disease. Therefore, if a treatment plan is agreed upon and started, it needs to be completed.

Commitment To Appointment

Your name in our appointment book is a bond of trust. It represents a mutually understood agreement that you will be present and on time for your appointment and that we will be here to serve you. Our office is very firm in this regard, and we will not tolerate frequent cancellations or constant short-change notices. We certainly understand that, occasionally, circumstances do arise that prevent patients from keeping scheduled appointments. We do request that, if you find you will be unable to keep an appointment with our office, you will give us at least a 24-hour notice, so that we may attempt to see another patient in your reserved time. Appointment changes are to be done directly with our Office Coordinator.

Commitment To Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

***payment is due at time of service.**

***if any insurance is involved, co-payment and any deductible are to be paid at the time of services are rendered.**

***we accept cash, check, MasterCard, Visa, Discover, and American Express.**

Dental insurance should be regarded as dental assistance. It is designed to help pay *some* of the costs of dental treatment. Because there are so many dental insurance companies and programs, it is nearly impossible for us to have complete knowledge of all of them. We will do our best to help you maximize your benefits. Dental insurance is meant to be a partial aid to defray professional fees. It is not designed to pay all of the costs of dental treatment.

Insurance is a contract between you and your insurance company. We are typically not a party to this contract. We file insurance as a courtesy to our patients. We are not required to become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, or other matters regarding reimbursement. The kind of benefits in your contract depend on what you or your employer have negotiated with the insurance carrier, and the amount of money you choose to pay in premiums.

I understand that I am responsible for all costs of dental treatment of what my insurance carrier may or may not pay.

Patient: _____

Date: _____

Composite Filling Treatment Consent

Our office uses no ‘silver’ filling material, also known more properly as amalgam. Silver amalgam has been the mainstay of dentistry for over 150 years. While it has served us well, the days of amalgam are numbered. Besides the fact that they become unsightly by turning black, amalgams have other drawbacks such as requiring removal of tooth structure beyond the decay in order to allow it to lock mechanically into the tooth. It also expands over time producing stresses that may cause cracks or fractures in the tooth.

Amalgam is also under scrutiny for its containing Mercury. While I personally feel that this is not an important reason not to use it, recently there has been class action lawsuits filed against silver filling manufacturers and the American Dental Association for the hazardous nature of the material. It is against the law to place silver filling material in pregnant women in many countries in Europe and even in the United States amalgam is considered ‘hazardous material’ unless it is in your mouth.

In my opinion, composite material is simply a better restorative material, even though it is much more difficult to place. If it is done well and maintained, it will last a long time. It is tooth colored, it is actually ‘bonded’ to the tooth, so there is no ‘gap’, and it allows us to remove only the bad part of the tooth to restore it back to natural function.

Unfortunately, some dental insurances are about 10 years ‘behind’ dentistry and do not cover composite fillings the same way they cover amalgams (after all amalgams are ‘cheaper’ for the insurance company, so they can keep more \$ in their pocket!). Most plans do however cover them the same. Your plan may or may not. If you need to be sure contact your plan administrator to find out. Some plans change our code for a composite to an amalgam, called ‘downcoding’ and pay at the rate of silver filling. We unfortunately can not always know what your plan will do until we submit your claim therefore, we are letting you know beforehand what could happen. In either event, **you** ultimately are responsible for the entire fee of the procedure, regardless of what your insurance pays.

I have read and understand the above:

Signed: _____