

# Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_ SS/HIC/Patient ID# \_\_\_\_\_  
First Middle Initial Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  Female  Male Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Do you prefer to receive calls at:  Home  Work  Cell  No Preference

Married  Widowed  Single  Minor  Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or parent's name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## Responsible Party

Name of person responsible for this account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employer # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit? \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?  No  Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_ Employer # \_\_\_\_\_

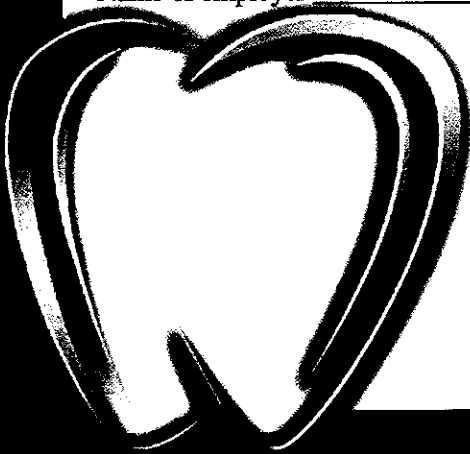
Insurance Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_

How much have you used? \_\_\_\_\_

Max. annual benefit? \_\_\_\_\_



# Dental History

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of last exam \_\_\_\_\_  
 Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_  
 Reason for today's visit \_\_\_\_\_  
 How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Please check any of the following conditions that apply to you:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to heat            |
| <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 your mouth |

# Medical History

Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_

Allergies: \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments     | <input type="checkbox"/> Hernia Repair         | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent        | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up blood           | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Bleeding Abnormally     | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Chemotherapy            | Describe _____                                    | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Respiratory Disease   |   |

Have you ever taken any of these medications?

- |                          |  |                                    |                                   |                                |
|--------------------------|--|------------------------------------|-----------------------------------|--------------------------------|
| <b>Diet Medications:</b> | <input type="checkbox"/> Dexfenfluramine | <input type="checkbox"/> Fen-phen  | <input type="checkbox"/> Pondimin | <input type="checkbox"/> Redux |
| <b>Blood Thinners:</b>   | <input type="checkbox"/> Coumadin        | <input type="checkbox"/> Warfarin  |                                   |                                |
| <b>Other:</b>            | <input type="checkbox"/> Levoxyl         | <input type="checkbox"/> Synthroid |                                   |                                |

# Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
Name of Insurance Company(ies)

and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

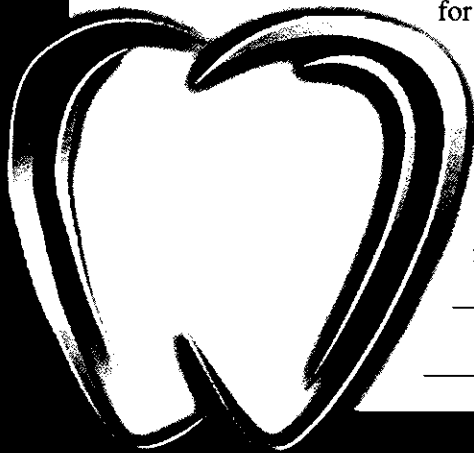
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Relationship



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## Gateway Dental Care

Robert N. Barber D.D.S.  
Christopher J. Erskine, D.D.S.

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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### SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Myrna Salcido  
Telephone: 480-279-4888  
Fax: 480-279-5005  
E-mail: N/A  
Address: 5656 South Power Rd. # 129, Gilbert, AZ 85295

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we take in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, \_\_\_\_\_ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_