WELCOME TO DR. PAUL GAMACHE'S OFFICE

Email:	Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:	Home Phone: ( )	Work Phone: ( )
Address:	City:	Cell Phone: ( )
Occupation:	State: Zip:	Date of Birth:
Social Security Number:		Sex: □ Male □ Female
Emergency Contact:	Relationship:	Phone: ( )

Dental Information *Please Mark (X) your responses to the following questions*

Do your gums bleed when you brush or floss?	□ Yes □ No	Do you have earaches or neck pains?	□ Yes □ No
Are your teeth sensitive to hot, cold, sweets or pressure?	□ Yes □ No	Do you have pain or discomfort in your jaw?	□ Yes □ No
Does food or floss catch between your teeth?	□ Yes □ No	Do you brux or grind your teeth?	□ Yes □ No
Are any teeth loose, chipped or broken?	□ Yes □ No	Do you have sores or ulcers in your mouth?	□ Yes □ No
Have you had any periodontal (gum) treatments?	□ Yes □ No	Do you wear dentures or partials?	□ Yes □ No
Have you ever had orthodontic (braces) treatments?	□ Yes □ No	Is your mouth dry?	□ Yes □ No
Have you had problems associated with dental treatment?	□ Yes □ No	Do you participate in recreational activities?	□ Yes □ No
Are you currently in pain or having any discomfort?	□ Yes □ No	Have you had a serious injury to head/mouth?	□ Yes □ No
What is your reason for your dental visit today?			
When was your last dental exam?		What was done at that time?	
How do you feel about your smile?		Date of Last X-rays:	

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems*

AIDS/HIV	□ Yes □ No	Glaucoma	□ Yes □ No	Radiation Treatment	□ Yes □ No
Anemia	□ Yes □ No	Heart Attack	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Arthritis	□ Yes □ No	Heart Disease	□ Yes □ No	Rheumatism	□ Yes □ No
Asthma	□ Yes □ No	Heart Murmur	□ Yes □ No	Stroke	□ Yes □ No
Blood Disease	□ Yes □ No	Hepatitis	□ Yes □ No	Sleep Disorder	□ Yes □ No
Cancer/Chemotherapy	□ Yes □ No	High Blood Pressure	□ Yes □ No	Sinus Problems	□ Yes □ No
Chest Pain	□ Yes □ No	Jaundice	□ Yes □ No	Stomach Problems	□ Yes □ No
Diabetes	□ Yes □ No	Kidney Disease	□ Yes □ No	Thyroid Problems	□ Yes □ No
Dizzy Spells or Fainting	□ Yes □ No	Liver Disease	□ Yes □ No	Tuberculosis	□ Yes □ No
Epilepsy	□ Yes □ No	Mental Disorders	□ Yes □ No	Tumors	□ Yes □ No
Excessive Bleeding	□ Yes □ No	Nervous Disorders	□ Yes □ No	Ulcers	□ Yes □ No
Emphysema	□ Yes □ No	Pacemaker	□ Yes □ No	Venereal Disease	□ Yes □ No
Codeine Allergy	□ Yes □ No	Do you Smoke/Use Tobacco	□ Yes □ No	Artificial Heart Valve	□ Yes □ No
Penicillin Allergy	□ Yes □ No	Do you drink alcohol?	□ Yes □ No	Previous Endocarditis	□ Yes □ No
Other Allergy:	□ Yes □ No	Currently Pregnant?	□ Yes □ No	Osteporosis	□ Yes □ No
		Due Date:		Joint Replacement	□ Yes □ No

Medications *Please list any medications you are currently taking*

Provider Signature (OFFICE USE ONLY)	**Date**

Referral Information *Whom may we thank for referring you to our practice?*

□ Dental Office	□ Yellow Pages	□ School or Work	□ Newspaper
□ Website/Internet Search	□ Another Patient (Friend or Relative)	□ Name of Person who referred you:	

Spouse or Responsible Party Information

The following information is for: □ The patient's spouse □ The person responsible for payment

Name:	Home Phone: ( )	Work Phone: ( )
Address:	City:	Cell Phone: ( )
Social Security Number:	State: Zip:	Date of Birth:
Occupation:	Relationship to Patient:	Sex: □ Male □ Female

Employment Information *The following information is for: □ The patient □ The person responsible for payment*

Employer Name:	
Address:	City:
	State: Zip:

Insurance Information

As a service to our patients we will submit your Dental Insurance Claim Forms. PLEASE KNOW YOUR PRESENT COVERAGE. Billing your insurance is an office courtesy.

Primary Insurance

Name of Insured:	Is the insured a patient? □ Yes □ No
Insured's Date of Birth:	
Insured's Address:	
City: State:	Zip:
Insured's Employer Name:	Patient's relationship to insured: □ Self □ Spouse □ Child □ Other:
Insurance Plan Name and Address:	

Secondary Insurance

Name of Insured:	Is the insured a patient? □ Yes □ No
Insured's Date of Birth:	
Insured's Address:	
City: State:	Zip:
Insured's Employer Name:	Patient's relationship to insured: □ Self □ Spouse □ Child □ Other:
Insurance Plan Name and Address:	

Consent for Services and Privacy Practices Acknowledgement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon the reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed with out previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimated listed for this dental care can only be extended for a period of six months from the date of patient examination.

In consideration from the professional services rendered to me, or at my request, by the Doctor, I agree to therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

I acknowledge I have read and understood the HIPPA Notice of Privacy Practices. _____ **INITIAL HERE**

Signature of Patient, Parent or Guardian	**Relationship to Patient:**	**Date:**
Signature of Guarantor of Payment/Responsible Party	**Relationship to Patient:**	**Date:**