Welcome!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible. If you have any questions, or we can help you in any way, please feel free to ask.

Patient Information (Confidential):

Name_____ (If Child, parent/guardian name)_____

Birthdate_____ Sex_____ Age_____ Soc. Sec. #_____

Home Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Which phone number would you like us to use when confirming? (please circle one) Home Work Cell

Email Address_____ Drivers License #_____

Employer_____ Occupation_____ How long there?_____ May we call?_____

Employer Address_____ City_____ State_____ Zip_____

Spouseôs Name (or other patient/guardian)_____ Soc. Sec. #_____

Spouseôs Employer_____ Occupation_____ How long there?_____ May we call?_____

Employer Address_____ City_____ State_____ Zip_____

If patient is **student**: Name of School:_____City & State_____ Full time or part time?_____

How did you hear about our practice? (circle one) Mail Newspaper Website Other:_____ or Referred by:_____

Primary Insurance:

Name of Insured_____

Birthdate_____Relationship to patient_____

Address (if different from patient)_____

Dental Insurance Co._____ Phone_____

Soc.Sec.#_____ Subscriber ID#_____

Group/Contract or Local or Union#_____

Additional Insurance:

Name of Insured_____

Birthdate_____Relationship to patient_____

Address (if different from patient)_____

Dental Insurance Co._____ Phone_____

Soc.Sec.#_____ Subscriber ID#_____

Group/Contract or Local or Union#_____

Insurance Terms:

To accept insurance, we now debit any patient balance automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information:

Name on card_____ Account #_____

Expiration date_____ CCV#_____

In case of emergency:

Someone we may contact, not living with you:_____ Phone Number_____

Authorization:

I authorize my insurance company to make payments directly to the dental office of Dr. Thomas Gibbs for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize us of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card for any unpaid balances, including those after insurance payment. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts. **SERVICE CHARGE** If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) at an annual rate of 18%

I authorize Dr. Gibbsô office to use clinical photography (not full face) of myself in professional or promotional materials.

I have received a copy of this officeôs Notice of Privacy Practices.

Signature_____ Date_____

Patient or Responsible Party

Medical History

Are you currently taking any medications? Yes _____ No _____

If yes, what? _____

_____

CHECK any of the following that you have had or have presently:

____Heart disease	____Heart Attack	____Artificial Heart Valve	____Heart Surgery
____Heart Murmur	____Heart Pacemaker	____Congenital Heart Lesions	____Abnormal Blood Pressure High/Low
____Hemophilia	____Abnormal Bleeding	____Anemia	____Sickle Cell Disease
____Bruise Easily	____Rheumatic Fever	____Scarlet Fever	____Liver Disease
____Thyroid Disease	____Arthritis	____Rheumatism	____Hepatitis, Which_____
____Pain in Jaw Joint	____Artificial Prosthesis	____Dizzy Spells	____X-ray or Cobalt Treatment
____Nervousness	____Diabetes	____Ulcers	____Epilepsy or Seizures
____Emphysema	____Tuberculosis (TB)	____Kidney Problems	____Unexplained Weight Loss
____Hay Fever	____Sinus Troubles	____Fever Blisters	____Chemotherapy: Cancer or Leukemia
____Cosmetic Surgery	____Night Sweats	____Respiratory Conditions	____Immune Deficiency Syndrome
____Glaucoma	____Fainting	____Drug Addiction	____Joint Replacement, Which_____

Other _____

Are you under a physicianôs care now? Yes _____ No _____

If yes, for what? _____

Are you allergic or have you reacted adversely to any of the following:

____Aspirin	____Vicodin/Other	____Erythromycin
____Darvon	____Local Anesthetic	____Latex
____Nitrous Oxide	____Codeine	____Iodine
____Penicillin	____Valium	____Sulfa

Are you aware of being allergic to any other medications? Yes _____ No _____

If Yes, what? _____

_____

Have you ever had to pre-medicate for a dental visit? Yes _____ No _____

Family Physician _____ Address _____

City _____ State _____

May we request your health records if needed? Yes _____ No _____

Are you pregnant at this time? Yes _____ No _____ If yes, how many months _____

Any hospital visits within the last 2 years_____ If yes, why_____

_____

Is there any other medical or dental information you feel we should know? _____

_____

Please list any immediate family members and or personal representatives you authorize the office of Dr. Thomas Gibbs to communicate your health care, condition and scheduling with _____

_____

Signature: _____ Date;_____

Patient or Responsible Party

Dr. Thomas Gibbs
Dental History

Patient Name: _____ Date: _____

What is the reason for todayôs visit? _____

Date of last dental visit _____ Reason _____

Date of last cleaning _____ Last x-rays _____

Previous dentistôs name _____

Address _____

Have you had complications with any previous dental treatment? _____

If yes, please explain:_____

How often do you have dental check-ups? _____

How often do you brush? _____ Floss?_____

What dental aides do you use? _____

What dental problems do you have now?_____

Are any of your teeth sensitive to: (please circle)

Hot or cold? YES NO
Sweets? YES NO
Biting or chewing? YES NO
Do you get cold sores or lesions? YES NO
Do you notice mouth odors or bad tastes? YES NO
Do your gums bleed or hurt? YES NO
Any loose teeth or change in your bite? YES NO
Does food tend to get caught anywhere? YES NO
Do you smoke/chew tobacco? YES NO
Do you clench or grind your teeth? YES NO
Do you mouth breathe while awake/asleep? YES NO
Have you noticed clicks or popping of the jaw? YES NO
Do you have difficulty opening or closing? YES NO
Do you have pain or difficulty chewing? YES NO
Are your jaws tired in the morning? YES NO
Iôm happy with the appearance of my teeth. YES NO
Rate your smile (on a scale of 1 to 10) _____
Do you want to keep all of your teeth for life? YES NO

Have you ever had:

Orthodontic treatment? YES NO
Oral Surgery? YES NO
Periodontal treatment? YES NO
A bite plate or mouth guard? YES NO
A serious injury to the mouth or head? YES NO
Your teeth ground or bite adjusted? YES NO
Pain in jaw, joint, ear or side of face? YES NO
Do you feel nervous about today's visit? YES NO

What is your biggest concern? _____

What did you like best about your last dental office?_____

_____

What did you like least?_____

Have you had an upsetting dental experience? YES NO

If so, what was it?_____

Is there anything else we should know?_____

_____

Please rank the following in the order they would KEEP you from having dental work:

1. Fear of pain _____
2. Cost of Treatment _____
3. Missing time from work _____
4. Embarrassed by dental condition _____

Dr. Thomas Gibbs, DDS, PC
Thomas R. Gibbs
HIPPA and Privacy Agreement

Dr. Thomas Gibbs and Staff (collectively labeled Dentist) agree to maintain Privacy of our patients as outlined in this HIPPA form. The Dentist takes pride in being able to extend a greater degree of privacy than is required by HIPPA, state confidentiality mandates, and common law.

Federal and State Privacy laws are complex. Unfortunately, come dental offices try to find loopholes around these laws. For example, HIPPA forbids dentists from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dentist believes this is improper and may not be in the patientsô best interest. Accordingly, Dentist agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Dentist will never attempt to leverage its relationship with Patientôs consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Dentist and his practice, expertise and/or treatment unless explicitly mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. Dentist has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Dentist; and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Dentistôs practice.

Dentist feels strongly about Patientsôprivacy as well as the practicesôright to control its public image and privacy. Both Dentist and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer (a) five years from Dentistôs last date of service to Patient; or (b) three years beyond any termination of the Dentist-Patient relationship. As a matter of office privacy, Dentist is requiring all patients in its practice to sign the Mutual or airing of commentary will be covered by the agreement for all Dentistôs patients.

Patient and Dentist acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Dentist agree to the right of equitable relief (including but not limited to injective relief). Should a breach of this Agreement result in litigation, te prevailing party in the litigation shall be entitled to reasonable cost, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations. We are required to provide you with a copy of our Notice of privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.
I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Patient_____ Date_____

Credit Card on File

In our efforts to continuously improve our patient service and office efficiency, you will be asked for a credit card number at the time you check in. That information will be held securely until your insurances have paid their portion and notified both you and us how much, if any, is your portion. At that time any remaining balance owed by you will be charged to your credit card and it will be presented on your statement.

This will be an advantage to you, because you will no longer have to write out and mail us a check. It will be an advantage to us as well, because it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

You can think of this as much like when you check into a hotel or rent a car; you are asked for a credit card which is imprinted and later used to pay your bill.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If your balance is more than $250 we will call you for approval.

If you have any questions about this payment method, do not hesitate to ask.

Credit Card on File FAQs

Why is Dr. Thomas Gibbs DDS requiring a credit card agreement from patients?
This practice will improve efficiency for everyone, and lower total costs of providing service to our patients. It will also allow us to focus our energies on providing dental care, rather than patient billing.

When will my credit card be charges?
As a courtesy to our patients, we submit claims to their insurance within a few days of providing the patient service. Claims are typically settled by insurance companies within 2 – 8 weeks after service was provided. Once a claim is adjudicated, your card will be charged for your portion.

How will I know how much the charge will be?
Insurance typically sends an Explanation of Benefits (EOB) to both the patient and the provider after claims have been settled that explains the contracted fees agreed between our office and the insurance. The EOB also shows whether any of the agreed upon fee must be paid by the patient. At that time, any patient balance is due in full.

What if I do not agree with the patient portion as specified by my insurance?
As the customer of the insurance company, patients can exercise procedures with their insurance for handling disputes as to whether insurance or patient is responsible for a particular fee. These procedures are typically regulated by state governments.
Our office's position is that the patient is ultimately responsible for the cost of the service provided, up to amount allowed by an insurance plan that our office accepts. We are not a party to disputes involving what portion of payment is the patient's versus the insurance's. Nonetheless, we will provide our expertise to our patients as a resource to help facilitate understanding of what their insurance company communicates to them about their contract.

What if I still do not agree with the charge applied to my card?
Our office's billing staff will review each patient's situation before applying a charge. In the event of any question or issue, please do not hesitate to contact our billing staff and we will work to resolve it as quickly as possible.
As a last resort, our patients should rest assured that credit card issuers typically have procedures for a cardholder to dispute a charge applied by any merchant. Credit card companies can typically suspend or reverse charges if they determine it was not appropriate.

What if I don't have a credit card, or do not want to participate? Is this mandatory?
Both your social security number and credit card on file is required. Subsequent to your visit a claim will be processed thru your insurance. Any remaining balance is then billed to you. Obtaining your security number and credit card helps avoid any financial issues.