Anthony Gardiner
D.D.S

New Patient Form

Patient Information

Name:
Address:
City:
Zip Code:
Telephone:
Alternative Phone:
Social Security:
Employer: Employer
Telephone:
Occupation:

Today's Date:
Referred By:
Sex: Male ○ Female ○
Birth date:
Height:
Weight:
Martial Status:
Spouse's Name:
Spouse's Number:

Individual Responsible for Billing (leave blank if the same as above)

Name:
Address:
City:
Zip Code:
Telephone:
Alternative Phone:

Sex: Male ○ Female ○
Social Security:
Employer:
Employer Number:
Occupation:

Patient's Emergency Contact

Name:
Telephone:
Alternative Phone:
Relationship:

Medical Physician

Name:
Telephone:

Medical History

(Please Select Applicable Answer)

1.) Your general health is?
2.) Is a doctor currently treating you? Y ○ N ○
3.) Any health changes in the past year? Y ○ N ○
4.) Have you been hospitalized or had surgery in the last 5 years? Y ○ N ○
reason?
5.) Have you had a blood transfusion? Y ○ N ○
6.) Have you had a facial or jaw injury? Y ○ N ○
7.) Have you had treatment for a tumor? Y ○ N ○
8.) Are you ever short of breath? Y ○ N ○
9.) Do you ankles ever swell? Y ○ N ○
10.) Could you be pregnant? Y ○ N ○
11.) Have you ever used diet drugs? Y ○ N ○
12.) Do you use tobacco products? Y ○ N ○
How often?
13.) Do you need a dental Premed? Y ○ N ○
14.) Are you or have you taken bone density medictation? Y ○ N ○
Type?
15.) Are you taking blood thinning medicaton? Y ○ N ○
Type?

Have you had any of the following?

CONDITION		ONSET DATE	CONDITION		ONSET DATE
AIDS	Y ○ N ○		High Blood Pressure	Y ○ N ○	
Anemia	Y ○ N ○		HIV+	Y ○ N ○	
Arthritis	Y ○ N ○		Implant	Y ○ N ○	
Artificial Joint	Y ○ N ○		(if so, what type?)		
(if so, what type?)			Kidney	Y ○ N ○	
Bleeding Disorder	Y ○ N ○		Psychiatric Disorder	Y ○ N ○	
Cancer	Y ○ N ○		Seizures	Y ○ N ○	
(if so, what type?)			Stroke	Y ○ N ○	
Hearing Loss	Y ○ N ○		Thyroid Disorder	Y ○ N ○	
Heart Attack	Y ○ N ○		Tuberculosis	Y ○ N ○	
Heart Murmur	Y ○ N ○		Ulcer	Y ○ N ○	
Hepatitis	Y ○ N ○		Stents	Y ○ N ○	

Allergies:
Reactions:

List Current Medications:

Insurance Information

Do you have dental insurance? Y ○ N ○
Would you like to set-up payment arrangements? Y ○ N ○

Primary Insurance Name:
Employer Name:
Employee Name:
ID#:
Employee Birth date:
Group or Policy Number:

Secondary Insurance Name:
Employer Name:
Employee Name:
ID#:
Employee Birth date:
Group or Policy Number:

AUTHORIZATION

I hereby authorize payment to be assigned to Dr. Anthony A. Gardiner of the Insurance benefits otherwise payable to me. I understand any amount not covered by insurance or if I do not have insurance covereage is my responsibility to pay the charged amount. The above dental and medical histories, the personal and insurance information are all correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and personal information to third party payers and/or other health professionals.

SIGNATURE
DATE

Notice of Privacy Practices - Acknowledgement

We keep record of the dental/health care services we provide to you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so, we refer you to another provider or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer.

Our Notice of Privacy Practices describes in detail how your health information may be used and disclosed and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

PRINTED PATIENT NAME
DATE
TIME

PATIENT'S SIGNATURE

SIGNING ON BEHALF OF PATIENT

RELATIONSHIP TO PATIENT

Submit